Resident Physician

JOURNAL FOR THE HOSPITAL STAFF OFFICER

JUNE
1960
VOL. 6, NO. 6

What to Look for in Disability Insurance

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ALSO:

ECFMG Exam Results page 61

Guide to Low-Priced Foreign Cars page 145

June 1960, Vol. 6, No. 6

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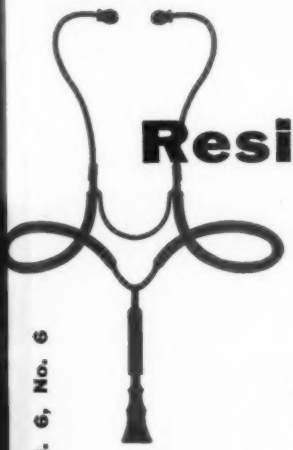

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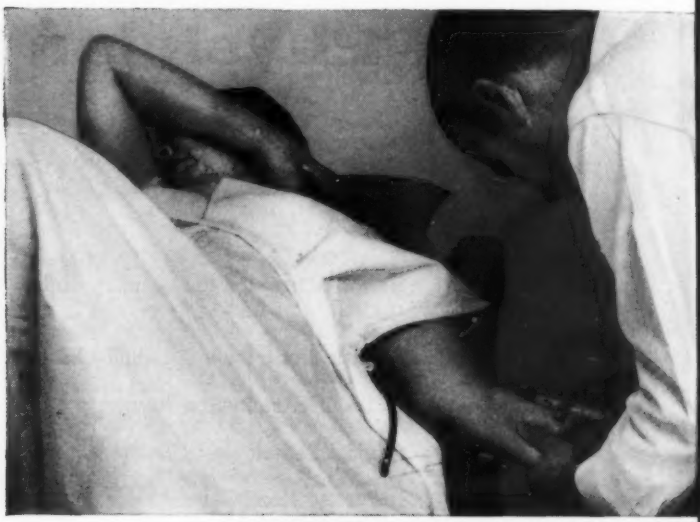
Control hemorrhage promptly & safel



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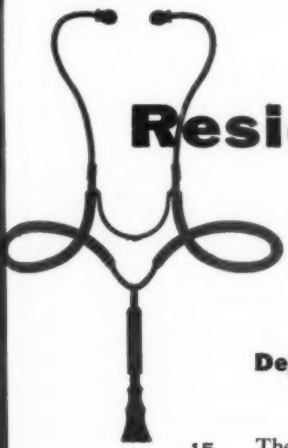

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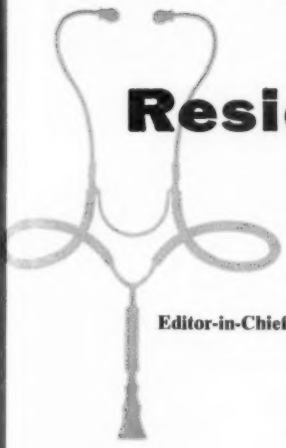

Resident Physician

Articles are accepted for publication with the understanding that they are contributed solely to this publication, and will directly interest or be of practical value to resident physicians and interns. When possible, two copies of the manuscript should be submitted.

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The Aged

–and a natural way to meet their special nutrition needs with fresh-flavor, economical Carnation Instant.

Finicky appetites, dental problems, food costs—one or more often play a part in contributing to poor diet for the elderly.

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One-third cup extra crystals per liquid quart when mixing provides 25% more calcium, protein, and B-vitamins than ordinary nonfat milk. Because your patients can add this additional amount, they get *needed* nutrients—*without* excessive calories. And the richer, more delicious flavor of nonfat milk mixed over-strength is a *natural* way to *extra* nutrition they'll enjoy. Costs them only 10¢ a quart.

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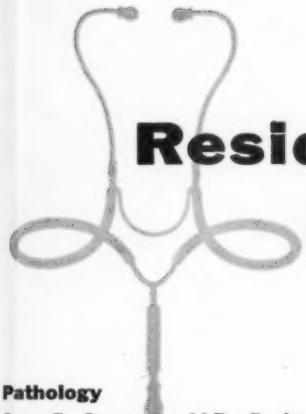

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Therapeutic Reference

The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All products are registered trademarks, except those with an asterisk(*).

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Combistix ..... Cover 3

"TIME-MATCHED" COMPONENTS

for smoother management of smooth muscle spasm

BUTIBEL

TIME-MATCHED — ANTISPASMODIC / SEDATIVE — COMBINATION

BUTIBEL combines two essentially synchronous components—belladonna extract and BUTISOL® Sodium. One or two tablets one-half hour before meals and at bedtime assures smooth, uninterrupted control of gastrointestinal spasm through the day and during the night.

Similar preparations containing phenobarbital, which has three times the duration of action of belladonna, must either build up a cumulative sedative burden or leave patients for long hours without effective antispasmodic protection.

By contrast, BUTIBEL, with its time-matched components, gives full, continuous antispasmodic *and* sedative action for smooth control of functional gastrointestinal disorders.

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Viewbox Diagnosis

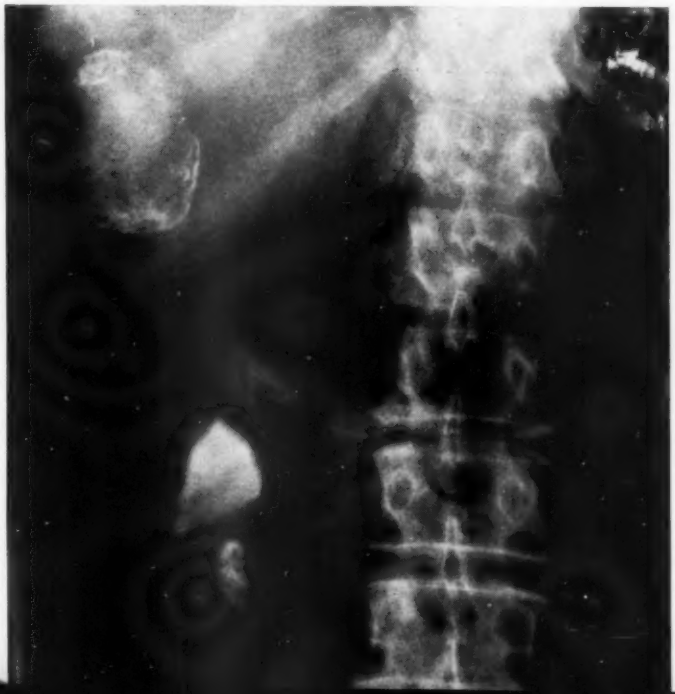
Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
Professor of Radiology, New York University College of Medicine
and Director of Radiology, Bellevue Hospital Center

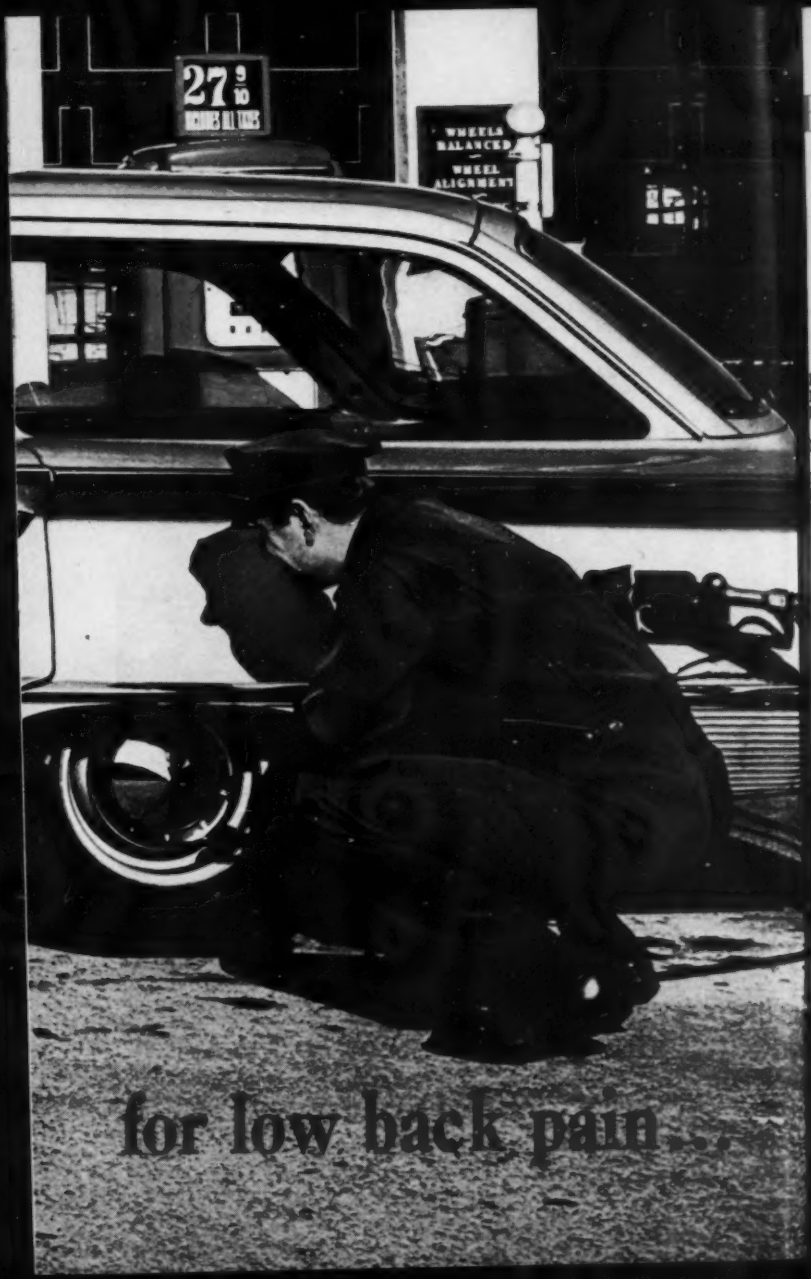
Fifty-eight-year-old Greek male. Chief Complaint: Right upper quadrant pain, not related to food intake. Lived in Greece for many years.

Which is your diagnosis?

1. Osteochondroma of rib
2. Echinococcus cyst of liver
3. Porcelain gallbladder
4. Calcified adrenal gland

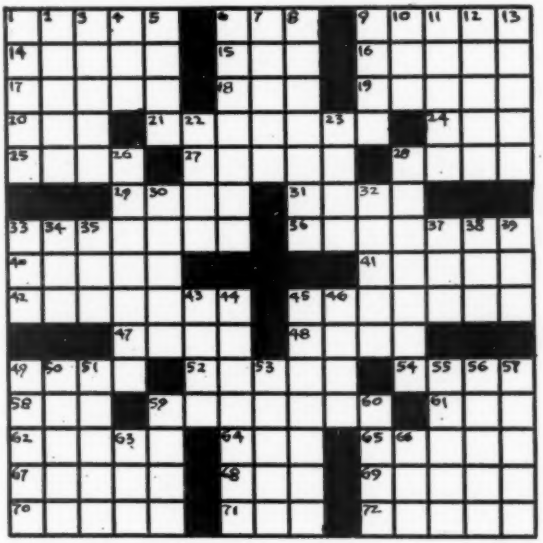
(Answer on page 162)




27 9/10
WHEELS BALANCED
WHEEL ALIGNMENT
for low back pain...

Resident Relaxer

(Solution on page 162)



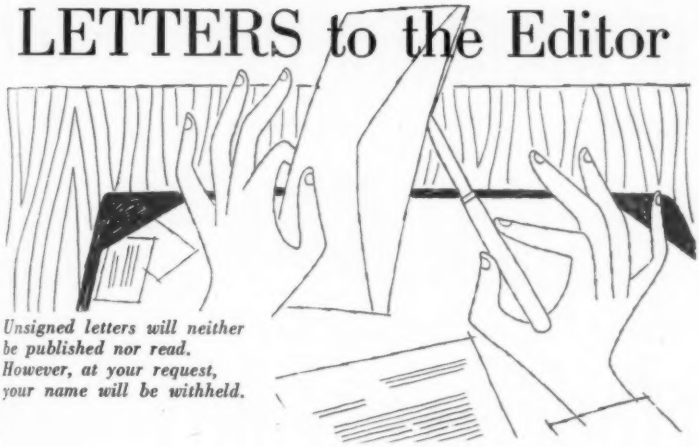
ACROSS

1. Pertaining to sight
6. Lower extremity
9. Impairment of motor function
14. Highways
15. Playing card
16. Ovum within the graafian follicle
17. Fluid secreted by the liver
18. With (prefix)
19. Himalayan kingdom
20. Prefix signifying "isomeric with"
21. Soon
24. Uranium, thallium (symbols)
25. Relating to a tendon (prefix)
27. . . . . operandi
28. Employs
29. Mineral springs
31. Den
33. A derived protein
36. Union of two solids to form a liquid
40. Sign of the Zodiac
41. Person with no mind
42. Tranquil
45. To make impure
47. Transformation (prefix)
48. Imitated
49. Gangrenous sore mouth
52. Guided missiles
54. On the outside (prefix)
58. Derived from a serum (prefix)
59. Paralyzed
61. Bone attached to a vertebra
62. Wash lightly
64. Iodine, molybdenum (symbols)
65. Escape
67. One who cannot speak (pl.)
68. Allied Youth League (abbr.)
69. Calcium oxide (pl.)
70. Prefix similar to amino
71. Left sacro-anterior position of fetus (abbr.)
72. Fall into disuse

DOWN

1. Bony socket which contains the eye
2. Unit of viscosity of a fluid
3. Part of a molar tooth
4. Suffix signifying binary compound
5. Cesium, antimony (symbols)
6. Milk sugar
7. Framework of a red blood corpuscle
8. A reproductive bud
9. Tissue connecting two parts of an organ
10. Hail
11. Tuberculous disease of the skin
12. List of candidates (U.S.)
13. Cries out
22. Unit of radium emanation in solution
23. Elder son of Isaac
26. Tumor composed of bone tissue
28. Eruption due to uremic poisoning
30. An armed band
32. Substance in milk
33. Golf term
34. Sooner
35. Chirp
37. Xenon, argon (symbols)
38. Internal (abbr.)
39. Devoured
43. Feminine name
44. A flower (pl.)
45. Smallpox
46. Himself (Lat.)
49. Line which defines aspects of the cranium
50. A narcotic
51. Mountain (comb. form)
53. Any odor
55. Spasmodic muscular contraction
56. Rise and fall of ocean surface (pl.)
57. Excessively fat
59. Mexican dollar
60. Ravine
63. Stool (L., abbr.)
66. A way or passage

LETTERS to the Editor



Unsigned letters will neither be published nor read. However, at your request, your name will be withheld.

Statement Unfair

Recently I saw an article in the March 20th issue of "Look" magazine about the dangers hospital patients face because of interns and residents qualified in foreign countries. I do not deny that there are charlatans among all of us, but making a general statement about the efficiency of all foreign qualified physicians is unfair. I can count quite a few, who have made outstanding contributions. It is only proper that recruiting hospitals should carefully screen the personnel they employ.

The said article has created an unfavorable atmosphere in the minds of the public who are naturally suspicious of everything foreign. I am sure that your magazine will be in a better position to assess the situation and express unbiased views. I trust you will take some action in this regard.

CHARLES R. ROQUET, M.D.
BALTIMORE, MD.

Language Articles

I am under the impression that your magazine ran a series of articles on medical terms in foreign languages, and how to ask for medical information in the languages—a dictionary of foreign medical terms, if you will.

I am interested in reprints of

—Continued on page 40

in premenstrual tension clinicians report rapid relief with

HYDRODIURIL®

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increased potency—without corresponding increase in side effects

IN YOUR FIRST INSTRUCTIONS

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3 basic vitamins	6 essential vitamins	10 significant vitamins

*0.6 cc. daily

Mead Johnson
Symbol of service in medicine

—*Continued from page 35*

these if they are available. Could you send them C.O.D., or if not, please tell me the cost, and I will promptly remit same.

Name withheld at writer's request

PHILADELPHIA, PA.

• *We did indeed run a series of articles on medical terms in foreign languages. The reprints of these articles are completely out of stock at the present time. In the near future we intend to republish the complete series of articles in* RESIDENT PHYSICIAN.

Night Calls

I want to send you a belated word of appreciation for the article, "What I Learned About Night Calls," which appeared in the February issue of your journal.

I just glanced at the title when I first received my copy of the journal, thinking it was one of those "how to" affairs that are really not very helpful. But recently I was going through old copies of various journals and came upon your "Night Calls." This time I read it through and was impressed by the practical value of the article and how much real meat there was in it. The author, Dr. Morris Soled, did a fine job.

I know there will be many problems I will have to solve for myself when I begin handling night calls, but I feel better prepared after having read this article. (It now reposes in a file, along with other material that I think will help me when I'm ready at long last to go out on my own.)

ROBERT PEARSALL, M.D.
DEARBORN, MICH.

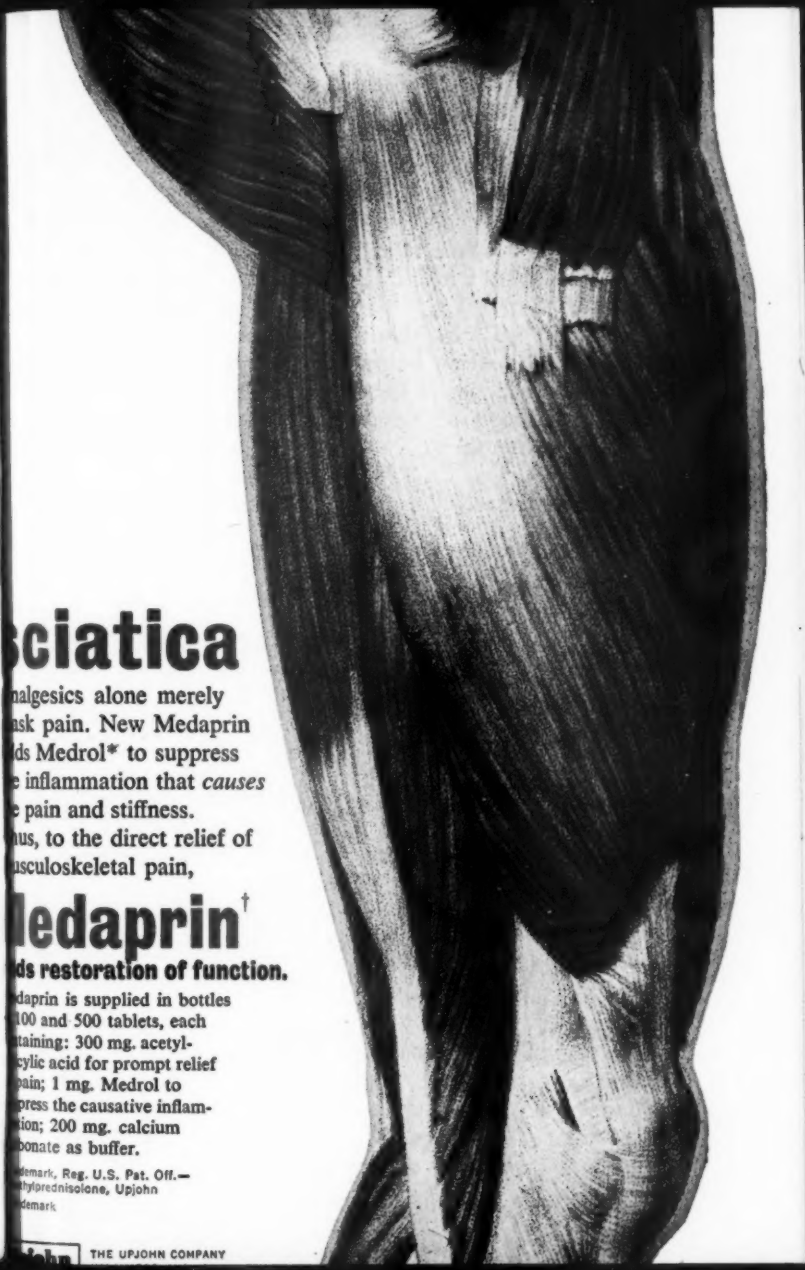
Haphazard Residencies

I have just finished reading Dr. Julius H. Comroe's article, "Our Haphazard Residencies: A Problem of Expediency" (April, RP), and I want to say "Amen!"

I am rounding out the last year of my residency and I know Dr. Comroe has put his finger on the problem when he says that "the service of the intern and resident to the hospital comes first and the educational obligation of the hospital comes second" and that "the internship - residency is not primarily a graduate educational experience. It is service-oriented and not education-oriented."

And is it not this same service orientation which is at the bottom of the mess involving the programs for foreign interns and

—*Concluded on page 44*



sciatica

nalgesics alone merely
sk pain. New Medaprin
ds Medrol* to suppress
e inflammation that *causes*
e pain and stiffness.
hus, to the direct relief of
usculoskeletal pain,

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daprin is supplied in bottles
100 and 500 tablets, each
taining: 300 mg. acetyl-
cylic acid for prompt relief
pain; 1 mg. Medrol to
press the causative inflam-
tion; 200 mg. calcium
bonate as buffer.

demark, Reg. U.S. Pat. Off.—
thylprednisolone, Upjohn
demark

THE UPJOHN COMPANY

—*Concluded from page 40*

residents? A great number of foreign physicians, it would seem, are brought to this country to fill jobs in hospitals rather than to increase their skills in training programs.

What does it all come down to? Money, I guess. How would the hospitals make out if they did not have a supply of interns and residents to run them?

J. T. R.

LOS ANGELES, CALIF.

Army Information

I'll be enlisting in the U.S. Army next month. In two of the issues of RESIDENT PHYSICIAN were articles on the Army Medical Officer, the processing procedures and the time he spends at Fort Sam Houston.

Please send me a copy of each issue or reprints of the articles.

ALFRED O. HEATH, M.D.
JEFFERSON MEDICAL
COLLEGE HOSPITAL
PHILADELPHIA, PA.

Perrin H. Long, M.D.

Editor's Page

ON THE QUANTITY AND QUALITY OF LIFE

III. A Discussion of the Prolongation of Life in the Incurably Ill and the Dying

With the cost of prolonged illness becoming excessive, even when one has Blue Cross or other insurance, with the failure of governments, Federal, state, and local to provide adequate means for the care of the aged despite the platitudinous mouthings of politicians at all levels, and with the emerging evidence that the American taxpayers will not exhibit a willingness to be taxed to the degree needed to support adequately the constantly increasing number of infirm people, more and more will be heard about "the quality of life."

As Mr. William McPeak[1] of the Ford Foundation said at the dedication of the Palo Alto Medical Center, "have we not begun to be preoccupied with the security and length of age . . . with the quantity of life more than the quality of living?" Are we right in expending such a large proportion of our medical resources in trying to increase the quantity of life at the expense

of its quality? Everyday in the wards of our hospital, an institution which is short of trained personnel in all categories except doctors, major portions of the time of nurses, practical nurses, and nurses aides are spent in increasing the quantity of life to the detriment of what might be done in improving the quality of life for other patients. Has not the medical profession missed the point in certain of its endeavors? Are we not piling up one Pyrrhic victory after another, while gradually losing the war. Are we not causing, as Dr. James Bordley, III has said,[2] "untold anguish to the patient and his friends, insupportable financial burdens for family and community, the diversion of medical resources from those who could use them more effectively, and a great increase in the cost of hospitalization for the average patient," just because we are more interested in increasing the "quantity" of life no matter at what painful cost to the individual or his community?

And with Dr. Bordley, we would like to point out that this is a very tough, in fact probably the toughest issue, which we as a profession have yet to face and with which we will have to deal over the next decades, because of its social, religious, ethical, and political aspects. But nevertheless, this issue must be faced by our profession. It should be pointed out that neither the problem nor its answer will be one concerning which euthanasia as generally understood will have to be considered. This to do with the extraordinary circumstances which the Western World has created. *It involves an ethical concept of who among us, has the right to exercise the power to deprive one of death?*

1. McPeak, W. Postgraduate Medicine, 27:119 (Jan.) 1960.
2. Bordley, J. III: Congress on Medical Education and Licensure. Chicago, Illinois. Feb. 6-9, 1960.

As has been said in Dr. Bordley's[2] presentation of the problem, "Today even the weakest arm unless restrained by a stronger, is sometimes capable of withholding for weeks or for months that one comfort" of the dying.

In concluding the discussion of this controversial and provocative subject, I would like to quote once more from Dr. Bordley:[2] "I don't think I need emphasize the bearing that this has upon the house officer's role in patient care. I would like to make the house staff realize that they were not shirking their responsibilities if some of the time and energy which they now feel compelled to spend in the cause of fruitless longevity were to be devoted to the factors which make it possible for their doomed patients to live in peace and comfort, and for their surviving patients to live more abundantly. I use this expression in the qualitative sense in which it was originally used in the New Testament, (St. John, 10:10, 'The thief cometh not, but for to steal and to kill, and to destroy: I am come that they might have life, and that they might have it more abundantly.') rather than in its more familiar quantitative sense." We cannot, as Christian or Jewish physicians, escape the problem of quantity and quality in life. It is up to us to reach an ethical and humane solution.

Perrin H. Long.

What to Look for in Disa

Based on nearly 30 years of association with the insurance needs of physicians and other professional men, the author gives you some vital pointers for your own insurance program.

Each of us has an economic life value. Specifically, as a resident physician preparing for practice, you have an economic life value of approximately $1 million. This is a conservative figure, based essentially on income you may expect to earn in the private practice of medicine or surgery.

The average resident physician will not start his specialty practice before age 30. Most will not start until later. This means you'll have approximately 35 years of outside practice before you reach age 65.

Certainly, no resident physician reading this article will doubt the fact that his income will average $25,000—$35,000 a year in private practice. You can easily see that this will approximate $1 million—or, your *economic value.*

Of course, you pay taxes on this income, perhaps 40% or so. Thus, your net economic life value is still over $600,000, a great deal of money.

Life Insurance

There is only one practical way to protect your family against the risk of loss of your economic life value. This is through the proper purchase of life insurance. Your practice, then, must not only support you and your family in a decent fashion but must also support a life insurance program which you should gradually expand toward a total protection of your economic life value.

You won't, of course, buy

Disability Insurance

Ralph K. Lindop

$600,000 of life insurance (the proceeds of which are income tax free to your family), but you should reach toward a figure where your death will not deprive your family of your entire economic life value.

Most young physicians must begin with term insurance. Most will want to convert or add to this some permanent insurance, as this becomes financially possible. This is to create enough retirement income upon which to live decently after you cut back on the unusually strenuous and self sacrificing life the physician must lead.

You face one other hazard which should be insured against: disability.

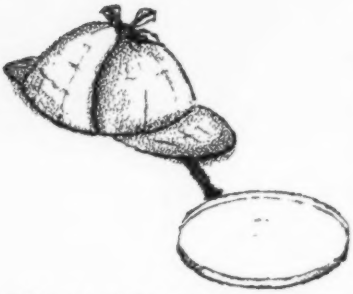
As a physician, you are in the position of an independent contractor. You fight to maintain the independence which you feel is vital to your profession and your practice.

You must pay a price for this independence. A part of the price is that when you are sick or hurt and cannot practice, your income is cut off.

On the other hand, your expenses continue. You keep your office open, continue to pay rent, telephone—all the bills.

Payments on your automobile go right on. The family has to eat and exist. You pay rent on your apartment or mortgage payments on your home. Expenses go on but income stops.

For this reason, the physician is in a more hazardous position than other men when he is disabled. He is not in the position of the man who owns a store



with six clerks and an assistant manager. The owner of the store can become disabled and for a long time receive excellent profits from his business; he could even sell his business at a high price. The physician on the other hand, receives nothing when he cannot practice. If he is disabled too long, he loses the practice he has laboriously built up. For these reasons, physicians buy more disability insurance than any other group on earth.

Services

Now let's look at the type and amount of disability insurance you should consider for purchase.

Seeking the services of an expert, most physicians locate a successful, honorable and well-informed insurance man. Some do not. This article is written solely to guide you in the essentials of adequate disability protection—which you must have or face the risk of catastrophe.

1. Your sickness and accident policy must first be noncancellable to a given age (Generally, this is age 65, when normal retirement age would be reached.) Most good companies state that even after 65, the company will, if the physician continues his practice, renew the policy from year to year but only at the company's discretion and not at a guaranteed premium rate. Even in this case, the individual's premium cannot be raised by the company after age 65 unless all physicians in his age group are also raised the same amount. (Before age 65, the rate is guaranteed.)

2. Not only should your policy be *noncancellable* to age 65, but the *premium should be guaranteed to age 65* which means that no matter what the company's experience is, they must renew your policy each year at the same guaranteed premium rate which you paid when the policy was first taken out. Several companies guarantee the premium rate to age 65.

3. The third most valuable feature for disability protection so far as the physician is concerned, is to be sure that he is insured against disability which prevents him from performing the duties of his usual occupation.

4. The policy should contain an *incontestable clause*. This simply means that after the policy has been in force for two years, the company cannot contest it for any misstatements in the original application.

5. Any policy purchased should be *nonaggregate*. This means that for each new disability, a fresh period of indemnity is payable. If this is not true, the time of disability will aggregate, thus making it highly probable that after several disabilities, you will no longer have any disability coverage left to you in the policy. You should look very carefully at the recurrence clause in your policy and see that it definitely states that for *each new disability a full two years of payments are payable*. This clause will also say that even for a *recurrence of the same disability,* the second heart attack, for example, the policy will pay a fresh two years (*provided six months of full recovery has occurred and the insured has been back to work between the two heart attacks).*

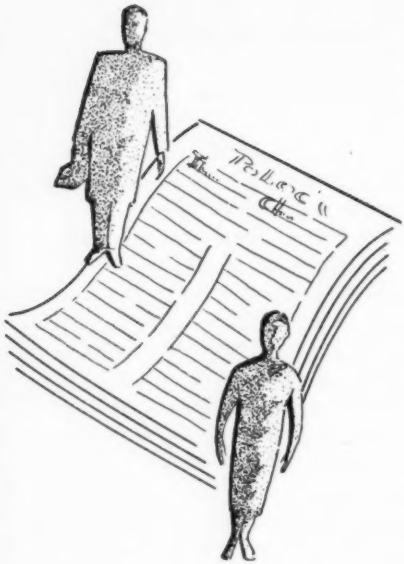
Had you purchased an aggregate contract, the policy would simply mean that each time you were sick or hurt, you would use up, irrevocably, a portion of two years, thus making your remaining coverage less and less each time. The premium, however, would remain the same.

6. In a disability policy which pays for loss of time, there should be *no exceptions as to the diseases covered*. No physician can predict in advance the disease which might incapacitate him.

7. Where accident is concerned, the physician stands, above all other professions, in a most vulnerable position. The amputation of a foot, for example, through an accident can mean a great curtailment of practice. For this reason, I advise the physician to purchase a minimum of five years of accident benefits and possibly lifetime. Both of these extensions are available with a number of companies.

8. There is always the question of when benefits are to start. *Accident benefits should start from the first day of disability.*

Sickness benefits should start no less than from the eighth day. Some companies recommend that 30 days be eliminated. Such an elimination period can be costly. Many diseases such as undulant fever and many others too numerous to name here, do not last over 30 days for each attack but recur so often as to make long elimination periods most costly. The premium saving is small and not worthwhile.



Group

Although the medical professional group has purchased the greatest amount of group coverage, *group insurance is cancellable insurance.* If you are going to hold a group policy, know that it is cancellable. It cannot be cancelled on a particular physician but it can be for a group—county group, state group or whatever group you may belong to.

It should also be understood that group insurance is segregated into the various groups insured, by the company insuring it. In other words, your county group may be losing money for the issuing company, while a group in an adjoining state, insured by the same company, shows a profit for the insurance company. In all likelihood, two things would happen: the group losing money would either be cancelled out by the insuring company or the price of the coverage would be raised. The group showing a profit to the issuing company would not be touched.

Where your disability protection is concerned, don't buy price —buy quality. In other words, my advice to you is to buy a policy which you will own personally—not a group plan. Make sure it is *noncancellable* and *guaranteed renewable.*

Major medical

Lastly, the physician should purchase the best major medical policy (sometimes called catastrophic medical) available. This policy shqulld be *noncancellable* and *guaranteed renewable.* (None is guaranteed as to price.) There are sound major medical policies available now which pay 80% of all expenses with *no deductible on accident* and with a $500 deductible on sickness. This covers the physician, his wife, and their children to age 19.

Be sure that in the major medical policy all children are covered from the *date of their birth, regardless of abnormalities.* Avoid policies which cover children beginning when they are 14 days old or 30 days old.

Skilled advisor

Just as the most important ingredient in your profession is your skill and your interest in your patient; so too, with your insurance man. Select an insurance man who obviously knows his business, who through his actions and entire demeanor demonstrates that his primary objective is to serve you. He must, of course, represent a company licensed in your state, one which is generally respected by your fellow practitioners.

Amount

As to amounts of individual, noncancellable guaranteed renewable sickness and accident coverage, a number of good companies write as much as $1,000 a month. This income is not subject to Federal or State income taxes. It is similar, in this respect, to income from municipal bonds. In other words, the $1,000 you would receive when you are sick or hurt and unable to practice medicine, is much more than $1,000. For example, if you were in the 50% tax bracket, it would be worth $1500 of income. The average young physician might feel that he could not pay the premiums for $1,000 a month of protection. If not, he should start with $500 and gradually add to it as long as his health remains good.

Overhead

The next purchase of disability insurance should be a type called "professional overhead." This insurance is intended to pay for practice overhead expenses when you are sick or hurt and can't practice, and can be purchased in amounts up to $800 a month. This type of protection is most desirable because the premiums are tax deductible. The income is not tax free because it goes for the payment of rent, salary of nurse, installments on equipment, upkeep of the car, etc.

Professional overhead policies should be *non-cancellable* and *guaranteed renewable.* (They are not guaranteed as to price by any company I have knowledge of.) This should not worry you where this particular type of protection is concerned.

In conclusion, as quickly as you can, build your purchases of income protection to $1,000 a

month. This should be noncancellable and guaranteed renewable at the same price to age 65. Two years on each sickness is in my opinion sufficient.

Next, purchase up to $800 a month of professional overhead insurance. Then, and only then, begin to buy group insurance if you feel that you need more income when you are sick or hurt.

The important thing is, *begin your purchases of life insurance and disability protection as soon as you possibly can.*

Both require you to be in good health at the time of purchase—and as a physician, you know better than anyone else that good health is seldom a lifetime gift.

"Well, instead of an appendectomy how about a chest x-ray? That's only five dollars."

ECFMG Examination Results

Majority of Foreign MD's Pass Big Test in U.S.

By now, the recent examinees of the American Medical Qualification Examination of the Educational Council for Foreign Medical Graduates have received the news.

For 1,650 who took the examination in the U. S., the news was good, a permanent certificate was awarded each. For another 1,118, the news was pretty good, a temporary certificate — good for two years—was awarded for grades of 70%-74%.

The total of 2,768 happy examinees represents 56.4% of the 4,909 who took the recent examination in the U. S. The remaining 2,241 failed to attain a grade of 70% or more and will be permitted to accept a six-month hospital appointment only if they indicate their intention to take the test again in September.

A summary of results of the five examinations given here and abroad since the first one in 1958 is shown in the table below.

EXAMINATION	N	GRANTED STANDARD CERTIFICATE N	%	GRANTED TEMPORARY CERTIFICATE N	%	TOTAL 70% OR ABOVE N	%
Mar. 25, '58	298	152	51	51	17	203	68
Sept. 23, '58							
U. S.	707	371	52.4	193	27.3	564	79.8
Abroad	137	47	34.3	33	24.1	80	58.4
Total	844	418	49.5	226	26.8	644	76.3
Feb. 17, '59							
U. S.	1278	616	48.2	341	26.7	957	74.9
Abroad	494	153	31.0	110	22.3	263	53.2
Total	1772	769	43.4	451	25.5	1220	68.8
Sept. 22, '59							
U. S.	2351	1088	46.3	601	25.6	1689	71.8
Abroad	717	282	39.3	141	19.7	423	59.0
Total	3068	1370	44.7	742	24.2	2112	68.8
Mar. 16, '60							
U. S.	4909	1650	33.6	1118	22.8	2768	56.4
* Abroad	1120	346	31.9	231	20.6	577	51.5
Total	6029	1996	33.1	1349	22.4	3345	55.5

* Pakistan not included

Educational Council for Foreign Medical Graduates

Sponsored by the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Federation of State Medical Boards, the ECFMG (Educational Council for Foreign Medical Graduates) was established in October 1957. Its purposes:

- To distribute information to foreign graduates around the world regarding opportunities and requirements involved in coming to the U. S. on an exchange visitor or exchange student visa to take training as an intern or resident in a U. S. hospital, or coming on an immigrant visa with the hope of becoming licensed to practice in one or more of the states.
- To provide certificates for foreign medical graduates, both in the U.S. or while in their own country, when such graduates qualify by fulfilling the following requirements: 1) Credentials—18 years of formal education, including at least 4 years in a bona fide medical school, 2) Pass examination on command of English, 3) Attain a passing grade on the American Medical Qualification Examination (AMQE).

The AMQE is a seven-hour exam comprised of morning and afternoon sessions — with the English test given during the afternoon period. The AMQE is

List of Examination Centers

U. S. CENTERS

California, Los Angeles
California, San Francisco
Colorado, Denver
Connecticut, New Haven
District of Columbia, Washington
Florida, Miami
Georgia, Emory
Hawaii, Honolulu
Illinois, Chicago
Kansas, Kansas City
Kentucky, Louisville
Maryland, Baltimore
Massachusetts, Boston
Michigan, Ann Arbor
Minnesota, Minneapolis
Missouri, St. Louis
New Jersey, Jersey City
New York, Brooklyn
New York, Buffalo
New York, New York City
New York, Syracuse
North Carolina, Durham
North Dakota, Grand Forks
Ohio, Cincinnati
Ohio, Cleveland
Pennsylvania, Philadelphia
Pennsylvania, Pittsburgh
Tennessee, Nashville
Texas, Houston
Virginia, Richmond
Washington, Seattle
Wisconsin, Milwaukee
Canada, Montreal
Puerto Rico, San Juan

FOREIGN CENTERS

Argentina, Buenos Aires
Aruba
Austria, Vienna
B. C. Colony, Hong Kong
Belgium, Brussels
Brazil, Rio de Janeiro
Chile, Santiago
Colombia, Cali
Cuba, Havana
Cyprus, Nicosia
Ecuador, Quito
Egypt, Cairo
El Salvador, San Salvador
England, London
France, Paris
Germany, Bonn
Germany, Frankfurt
Germany, Munich
Greece, Athens
Haiti, Port-au-Prince
Iceland, Reykjavik
India, Bombay
India, Calcutta
India, Madras
India, New Delhi
Iran, Tehran
Israel, Tel Aviv
Italy, Rome
Japan, Tokyo
Korea, Seoul
Lebanon, Beirut
Mexico, D. F. Mexico City
Nassau
Netherlands, The Hague
New Zealand, Wellington
Nicaragua, Managua
Pakistan, Dacca
Pakistan, Karachi
Pakistan, Lahore
Panama, Panama City
Peru, Lima
Philippines, Manila
Portugal, Lisbon
Spain, Madrid
Switzerland, Bern
Syria, Damascus
Taiwan, Taipei
Thailand, Bangkok
Turkey, Ankara
Turkey, Istanbul

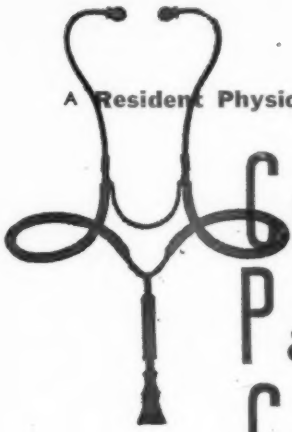
offered twice each year (Spring and Fall) in some 85 centers in the U. S. and foreign countries. Examinations are comprehensive, largely clinical, and questions are chiefly objective, multiple-choice. These consist of 1) completion type, 2) association and relatedness type, and 3) case histories. Different combinations of questions are selected for each examination from a large pool of questions. Each question has been used previously in either National Board examinations or State Board examinations.

The next examination is scheduled for September 21, 1960. It is most important that you notify the ECFMG *where* you wish to take the examination.

Any applicant who finds it impossible to plan to be examined in one of the listed centers should notify the ECFMG promptly. No changes will be permitted in the selection of centers after July 21, 1960 (for the September 21, 1960 examination).

It is also necessary that by those same dates, the ECFMG office has your address (to be used in notifying you of the exact time and street address of the examination).

You will be advised as to the exact time and street address by September 9, 1960 for the September 21, 1960 examination. Address your letters to the ECFMG at 1710 Orrington Avenue, Evanston, Illinois.



A **Resident Physician** MONTHLY FEATURE

Clinical Pathological Conference

HARTFORD HOSPITAL, Hartford, Conn.

This 50-year-old white female housewife was admitted to the New Haven Hospital for the first time on September 28.

Chief Complaint: Shortness of breath of 2 weeks' duration; anemia.

Present Illness: One to two months before admission the patient had noticed that her abdomen began to swell, although this caused her no discomfort. Two to three weeks before admission she had experienced increasing exertional dyspnea with occasional paroxysmal nocturnal dyspnea and ankle edema. She had had 2-pillow orthopnea for two years. For two to three days before admission she had had postprandial vomiting without nausea. The vomitus consisted of ingested food without evidence of blood. She complained of nocturnal pruritus for three weeks before admission.

Past History: Noncontributory.

Family History: Noncontributory.

There had been no recent weight loss. She had experienced a rash over the arms and chest of

JOHN C. LEONARD, M.D., *Discussant,* is director of medical education at Hartford Hospital.

AVERILL A. LIEBOW, M.D., *Pathologist,* is professor of pathology at Yale University.

a macular type for two or three years. Four years previously she had been seen by a doctor for a minor complaint and at that time was found to be anemic and "run down." During the previous winter she was noted to have a "puffy" face. During the past year, and especially in the past six months, she had been troubled with diarrhea, at times so severe that she had been incontinent of feces.

Physical

Temperature was 99 to 100; respirations 28; blood pressure 160/95. This was a swarthy woman appearing chronically and moderately acutely ill. She was somewhat dyspeneic.

Skin: There was no evidence of jaundice. Numerous small "scabs" and excoriations from scratching were present over the back, chest and arms. *Head, ears, nose:* Negative. *Eyes:* Pupils were equal. The sclerae were clear. There was slight exophthalmos, without staring. The vessels of the fundi were thin and faint. *Mouth:* The upper incisors were infected. The lowers were absent. The tongue was poorly papillated, with flat areas at the periphery and in the center.

Throat: Moderate postnasal drip. *Neck:* The thyroid was slightly enlarged, the right lobe greater than the left. No nodules were palpable. The neck veins were distended and filled from above. *Lymph nodes:* Many 1 to 2 cm diameter soft nodules in both axillae. *Thorax:* A-P diameter was increased and the chest cage was relatively fixed with full inspiration.

Lungs: Inspiratory wheezes at the left base, posteriorly and laterally. Clear to percussion. *Heart:* The heart was enlarged to the left anterior axillary line with the apex in the 6th interspace. There was a Grade II systolic murmur, heard best at the apex. The rhythm was regular with frequent extrasystoles. *Back:* No CVA tenderness. *Breast:* No masses palpable.

Abdomen: The abdomen was very protuberant with a 2 cm diameter umbilical hernia, easily reducible. A mass, thought to be a greatly enlarged liver, extended

into the pelvis on the right. It was non-tender with a hard nodular surface. There was a vague mass in the left flank, without a definite edge and with multiple slightly movable 2 to 4 cm diameter hard nodules over the surface. In the remainder of the abdomen could be felt small, hard, slightly movable nodules, on deep palpation.

Skeletal: No tenderness of the spine or rib cage. *Pelvis:* Not remarkable except for cervical erosions. *Rectal:* No masses palpable. *Extremities:* There was edema of the lower extremities. *Neurological:* Not remarkable.

Hospital course

She was treated with fluids and blood transfusions, and digitalized. She remained dyspneic but expressed very little concern over her illness. The venous pressure on 9/28 was 252 mm of water, and the circulation time (Decholin) was reported to be 60 sec.; (questionable accuracy). An ECG taken on the same day showed nothing of note. On her fourth hospital day she developed a temperature of 103 and was found to have bronchial breathing, with rales over the right lower lung posteriorly and with dullness at the base.

She was placed on Aureomycin with prompt return of her temperature to normal. Tarry stools were noted on 10/3 and continued throughout the remainder of her hospital stay. On 10/3 she was noted to have generalized anasarca with puffiness of the arms, face and neck. A thoracentesis was performed and 400 cc of slightly cloudy fluid was obtained. On 10/4 she became somewhat confused. On 10/6 she became unresponsive, and on 10/7 she died.

X-ray

Abdomen: Displacement of duodenum and small intestine toward left. Barium enema: Evidence of extrinsic pressure on lateral aspect of ascending colon. Chest: Density in right lower lung field. Pleurisy with effusion.

Discussion

DR. LEONARD: A middle-aged female of 50 years was admitted to the New Haven Hospital on September 28. Since she died on October 7, she was there under observation and therapy for ten days. Her chief complaint was shortness of breath. For two to three days before admission, she had had postprandial vomiting without hematemesis. She complained of nocturnal pruritus for three weeks before admission.

Laboratory Data

BLOOD

	RBC	HGB.	WBC	STAB	LYMPHS	SEG.	HCT.
9/28	2.33	8.7	19,000		15	85	
10/1			10,000				34
10/2	2.86	9.5	10,900	12	9	79	
10/4			12,150				52

BLOOD INDICES 9/30

C.I.	1.017	MCV	108	21
V.I.	1.29	MCH	37	
S.I.	0.82	MCHC	29	

URINE

	REACT.	SP. GR.	ALB.	SUGAR	ACETONE	CASTS, ETC.
9/29	5.5	1.013	1+	0	0	5-10 wbc
9/30		1.005	3+			50-100 wbc; 5-10 rbc
10/6	6.0	1.007	3+			Bacteria; Loaded with wbc & rbc

	NPN	FBS	Na	Cl	CO_2	K
9/29	181	99	128	105.5	5.6	5.6
10/1	180		136.7	93.7	19.0	3.6
10/6	165		114.5	82.0	14.5	

LIVER FUNCTION TESTS 9/30

Bilirubin: Total 1.18; BSP 42.2
Alk. phosphatase 18.5

Ceph. Floc. 4+ 4+
Direct 0.68
Thymol turbidity: 8.5

Thymol flocculation: 2+
Urobilinogen: 0.13

BILE: 0; **PROTHROMBIN TIME:** Control 14 sec. Patient 20 sec. P.T. 44%

STOOL 9/30: Guaiac 3+ **BLOOD CULTURES 10/2 and 10/3:** No growth

THORACENTESIS FLUID 10/3

Specific Gravity 1.013
Loaded with wbc

Culture: Negative
Cell Block: No evidence of tumor

When we think in terms of pruritus, we still should think of scabies, because it is not necessarily a disorder of poor economic circumstances. We should think in terms also of malignant lymphoma, because it is amazing how frequently lymphoma shows up even before nodes or spleen are evident, just on the basis of the symptom, pruritus, and the obvious scratch marks that so many of these people have when they are admitted.

Rash

She had experienced a macular rash over the arms and chest for two to three years. We aren't told this patient's race, but the late Dr. Francis Blake used to pick us up about once a year on the basis of these rashes, which he would come along and identify immediately as Brill's Disease.

Four years previously she had been seen by a doctor for a minor complaint, and at that time was found to be anemic and "run down." The diagnosis "run down" is a lay diagnosis which is used very often to explain chronic fatigue.

Nine to twelve months before her admission, she was noted to have a puffy face, and our attention should turn immediately to hypoalbuminemia, regardless of what the cause of the hypoalbuminemia might turn out to be.

During the past year she had been troubled with diarrhea, at times so severe that she had been incontinent of feces, so that this was really a severe diarrhea, almost certainly of the watery variety. Later on we find that the laboratory gives the evidence of 3+ Guaiac-positive stools.

Her physical examination showed a temperature of 99 to 100 degrees Fahrenheit. The pulse isn't mentioned. Her respirations were elevated to 28, and her blood pressure was 160/95. You always wonder, when you find a blood pressure at this level on admission, whether the patient has previously had a severe hypertension and whether, because of cardiac failure, the pressure has been reduced to this level, or whether she might have been a normotensive individual and her blood pressure was now on the rise.

This was a swarthy woman, and we are always alerted to anything that describes the skin. I don't know whether this swarthiness was racial or whether it was something she had acquired with her disorder. It is almost certainly not Addison's disease. She was not a diabetic, so we shouldn't think too seriously along the lines

of hemochromatosis or hemosiderosis. The sclerae were clear so that there was no jaundice, which almost completely rules out any serious degree of bilirubin elevation.

Stare

There was slight exophthalmos with stare. The vessels of the fundi were thin and faint. Thin vessels might well go with long-standing hypertension, so that probably this patient's blood pressure has been elevated for some time. The faintness may well have been tied in with retinal edema, although no specific mention is made of that. At least there were no hemorrhages and no exudate described.

The upper incisor teeth were infected, and the tongue was poorly papillated, with flat areas at the periphery and in the center. With what we see in the hemogram later, we begin to wonder whether a part of this patient's disorder might be pernicious anemia.

The throat showed moderate postnasal drip, and I think we could almost say that merely means that she was a "normal New Englander."

The thyroid was slightly enlarged, the right lobe greater than the left. This again makes us wonder whether she came from this section of the country, or whether this was a very minor and insignificant finding. No nodules were palpable in the thyroid, so perhaps we can pass over that.

The neck veins were distended and filled from above. She did have definite evidence of congestive failure in this manner and otherwise.

This patient did have, significantly, one to two centimeter soft axillary nodes bilaterally.

Inspiratory wheezes were noted at the left base, posteriorly and laterally. The chest was clear to percussion. The heart was enlarged, and this was confirmed by the x-rays that Dr. Liebow was kind enough to send up in advance. Grade II systolic murmur was heard best at the apex. The rhythm was regular with frequent extrasystoles, and later the statement is made that the ECG was normal.

Umbilicus

The abdomen was very protuberant with a two centimeter umbilical hernia, easily reducible. Our good friend, Dr. S. J. Thannhausser, always pays much attention to the appearance of the umbilicus and says that any time you see a pouting umbilicus, you

should definitely look carefully for intra-abdominal disease. A mass, thought to be a greatly enlarged liver, extended into the pelvis on the right, so this was no small organ.

A liver that extends into the pelvis, though we do see it occasionally, leads one to think of malignancy with a metastatic liver. It was nontender with a hard nodular surface. We are not told whether this mass that was thought to be liver moved with respiration. It is extremely important to note whether an abdominal mass moves with respiration. There was a vague left flank mass, so we have bilateral masses here. In the x-rays later we see that the mass on the left is also very large. There is no mention of the spleen here.

Mass

This vague mass in the left flank was without a definite edge but did have multiple slightly movable 2-4 cm diameter hard nodules over the surface. It would be very unusual for nodules that were metastatic in the liver to be movable, so perhaps we should pause here and think very carefully over that statement. In the remainder of the abdomen could be felt small, hard, slightly movable nodules on deep palpation. Immediately you wonder whether the mesenteric nodes are also involved—perhaps even the retroperitoneal nodes. There was no skeletal tenderness or pain, and I think probably this is significant.

her congestive failure in the form

There was further evidence of of edema of the extremities—or perhaps we should say failure and/or hypoproteninemia.

Neurological examination was not remarkable, despite the fact that this patient did go into coma the last two days of her life.

Hospital course

She was treated with fluids and blood transfusions and was digitalized. She remained dyspneic despite all this, but expressed very little concern over her illness, which is often true of a patient who is so seriously ill that she is either numbed on the sensory side or has been ill for so long that she takes her symptoms for granted. The venous pressure was 252 mm of water, and the circulation time (Decholin) was 60 seconds. An ECG showed nothing of note. Four days later, her temperature was 103.

She had bronchial breathing with rales over the right lower lung posteriorly, with dullness at the base. She was placed on

Aureomycin with prompt return of her temperature to normal. Tarry stools were noted on 10/3, which is two days after she was given Aureomycin, and her diarrhea, previously watery and now bloody, continued throughout the remainder of her hospital stay. Four days before her death she was noted to have generalized anasarca, with puffiness of the arms, face and neck, so that what was hypoalbuminemia on admission must have become worse by this time.

Fluid

Thoracentesis was performed, and 400 cc of slightly cloudy fluid was removed from the right pleural cavity. Paracentesis was attempted, but no fluid was obtained. That seems quite strange in view of the films we will show later, because there is tremendous haziness in the x-ray all over the abdomen. Three days before death the patient appeared somewhat confused, and for the last two days of her life she was apparently in coma.

She had a 2.33 million red blood cell count on admission and on 10/2 the count was 2.86 million despite the fact that she probably had a fair number of transfusions, although we do not know the exact number. However, her hematocrit was 34 on admission and 52 just before death so that her anemia was quite corrected, or this may have been caused by dehydration due to diarrhea. Her white count was elevated constantly, and the granulocytes were always markedly elevated. The blood indices would indicate a macrocytosis with some hypochromia. The macrocytosis is not marked enough that I think we have too much right to lean toward pernicious anemia, despite the tongue. Apparently the bone marrow was not examined. I'm not going to think too seriously of pernicious anemia.

Microscopic findings

The urine was acid on admission. Specific gravity reached only 1.016 with the help of 1+ albuminuria. Albumin was one-to-three plus in the urine, with no sugar and no acetone. Microscopic findings were significant with white cells, red cells, and bacteria. If it was not a catheterized urine, it doesn't mean anything. I think, the way this is building up, that we should take seriously the white cells, red cells, and bacteria in this patient's urine.

The NPN was markedly elevated despite attempts at fluid restoration. Her fasting blood

sugar was normal. Her sodium at first was a little bit low, then was restored by electrolytes, and finally dropped toward the end. Her chlorides at first were normal, but, in keeping with dropping of the sodium indicating kidney disease, she had lowering of her chlorides. Her CO_2 was in the acidotic range at first, was brought toward normal, and then dropped again despite attempts at electrolyte balance. Her potassium was elevated at first and then finally on the low side. We wonder, with a high NPN, whether the potassium shouldn't have been higher than this, but perhaps this patient, who was having marked diarrhea, was losing her sodium and potassium excessively in that manner. I suspect also that she was being given potassium, and that still failed.

Tests

Her liver function tests are extremely important. Her total bilirubin was only 1.18, and of that, the direct or immediate reacting portion was 0.68. It is obvious now why she did not have any jaundice despite the fact that her liver function was abnormal. Her BSP was a markedly abnormal 42.2%. Her phosphatase was elevated to 18.5, indicating some extrahepatic obstruction of which we have no evidence in the normal, or near-normal, bilirubin. Therefore, we have to wonder about intrahepatic or skeletal damage.

We have nothing to go with skeletal disease clinically or in the x-rays. Therefore, we have to bring this back to the liver. The cephalin flocculation is in keeping with that, 4+ after 24 and 48 hours. This indicates for one thing at least a high globulin, and that goes along with a very low albumin, which we have been prophesying. The thymol turbidity is up to 8.5 with an abnormally elevated thymol flocculation, indicating hepatocellular damage. The prothrombin time was somewhat abnormal, being reduced to 44%, which is in keeping with the other abnormalities of liver function.

Guaiac

Here is something important —her stool Guaiac was 3+, and this was before her bloody diarrhea — so, even then, she was losing blood from the GI tract. Blood and chest fluid cultures were negative. We have no indication of malignancy or infection, or, if the latter was there, it had been controlled, as far as the chest was concerned, by the antibiotic. We don't have a serum

protein and A/G ratio, but I feel that the albumin must have been very low and perhaps, therefore, the globulin higher than normal. We have no gastric analysis to lead us toward pernicious anemia or gastric carcinoma with metastasis to the liver and nodes. A BSR probably wouldn't help, since we already have an elevated white count and a polynucleosis to go with it.

X-rays

The large mass which was thought to be liver, pushed the stomach, duodenum, and small bowel to the left side of the abdomen. Apparently there is also a left sided abdominal mass, but we do not know if this could possibly be the spleen. The kidney contours are not recorded the way they usually are in a flat film. A marked diffuse haze is present over the flat film, and that should mean that there is a great deal of fluid in the abdomen. We see no stones or calcification. The heart is enlarged and there is evidence of fluid here, and perhaps infection, but the rest of the lungs are clear. There is no evidence of metastatic disease.

Obviously, this is unlikely to be a carcinoma of the lung, because we don't have enough to go with that picture. There is no doubt about cardiac enlargement and congestive failure. We must feel that there is a retroperitoneal mass. With the multiple systems involved, in spite of the presence or absence of the spleen, one should think of malignant lymphoma. Only a few axillary nodes are present, and this worries one a bit. This patient did have pruritus, but an elevated bilirubin was absent. Abdominal lymphoma may displace normal viscera, and this is not too rare. That might be why no free fluid was ever obtained.

Differential

Here is a patient with congestive failure and uremia. The "scratch marks" on the arms probably account for the axillary nodes. She has evidence of massive renal impairment going on to uremic coma. There is an important syndrome with congestive failure that ends in uremia. We should also keep in mind that people who have that form of renal disease often have terminal infection which accounts for the urinary findings. The diagnosis that would tie it all together is *Congenital Polycystic Kidneys.*

This picture, from an old textbook, shows a massively enlarged polycystic kidney and a smaller one on the left. This patient

should have "spider" pelves in her kidneys.

DR. LIEBOW: One of the things that I always enjoy about Dr. Leonard's clinical analyses is that he often corrects the protocol and suggests additional procedures that should have been done but were not done. Very frequently, when the clinical analyst makes a misdiagnosis from a protocol such as this, he gives as a reason that he hasn't seen the patient. In the present instance, the opposite is true, and those who did see the patient were not successful. The x-ray department, however, suggested the correct diagnosis—and also made an alternative diagnosis that the patient had an intra-abdominal tumor, a lymphoblastoma.

I think it is unfair that Dr. Leonard demonstrates the pathology in this case from an old textbook. The kidneys were somewhat larger than shown in that old volume, and they did extend much lower. The entire substance of both kidneys had been transformed in this manner and when a section was made, and the spiderlike nature of the calyces within the substance of the kidneys is demonstrated.

It is interesting that there are two periods of life when the mortality is relatively high. The first is in early childhood. The second is somewhere in the forties, as a rule. This patient was a little older. Now, why should there be this gap, and what is the mechanism by means of which renal failure finally occurs in these patients? The neonatal deaths are explained by the totally deformed state of the parenchyma with lack of capacity to function that exists in a few individuals. Here the kidney has the appearance of a sponge; not coarsely cystic as in the present case.

Second group

In the second group there is less diffuse involvement, but other changes take place. Some of these can be demonstrated in the present instance. At the margin of the cyst is seen a tremendously distorted collecting tubule, in consequence of being stretched on the periphery of the cyst. The very same thing happens to blood vessels. In this way, there is an increase in those factors that tend to destroy the glomerular substance. Arterioles become thick-walled, and their lumina become obliterated as they are stretched. Likewise, as the tubules become stretched on the surface of the cyst, there is ultimately a tendency for atrophy of the proximal nephrons.

Congestion

The heart was somewhat enlarged, and there was fluid in all the serous cavities. In the liver, a few cysts could be seen grossly. There was a severe degree of passive congestion in the liver, with actual necrosis of parenchymal cells in the pericentral regions.

In addition, there were certain foci of necrosis which had the appearance of infarcts. A few of these were situated near large cysts, and the associated vessels show evidence of thrombosis.

Infarcts of the liver are extremely rare, unless there is a combination of impairment of both sources of afferent blood supply—that is, both the hepatic arteries and the portal veins. In this case, portal veins have become thrombosed. The arterial circulation is impaired by virtue of the heart failure that exists.

The lungs showed severe congestive changes, and there were numerous very small pulmonary emboli.

The bladder was the seat of a severe cystitis. The x-ray diagnosis was *Cystitis Emphysematosum,* meaning by that that gas-forming organisms had actually invaded the wall and produced gas there.

The final diagnosis, then, is *polycystic disease, involving kidneys and liver; congestive heart failure; focal infarcts of the liver and passive congestion.*

DR. LEONARD: These patients are difficult to keep in electrolyte balance. They are always anemic. As one looks back, there is no doubt that when she was seen by a physician four years before and found to be anemic and "run down," the enlarged cystic kidneys should have been felt if an attempt had been made. I think it is entirely justifiable that we stress the examination, because in that manner we would be led to doing an IVP and finding these people early. They could then be given what little protection there is to be given, admitting that it is very slight. At least they can be kept in as normal electrolyte balance as possible.

There is one other point you see mentioned in the literature, and that is that some of these patients can be treated by evacuation of these cysts. That is in the line of wishful thinking. Obviously, this procedure does not increase renal function in these people. Also, 98 percent of these patients have bilateral involvement of the kidneys. About eight or ten cases are reported in which malignancy developed in a polycystic kidney.

IT PAYS TO READ CURRENT MEDICAL LITERATURE

Designed to stimulate your reading of medical journals Resident Physician's Mediquiz Contest begins in the August issue. Contest questions of the same multiple-choice type as in our regular monthly Mediquiz feature will be compiled from material published in current medical journals. In addition to the value you will derive from your reading, Resident Physician offers you an extra special inducement, an opportunity to share in

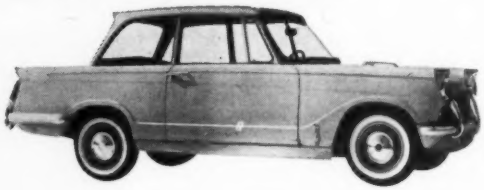
. . . over $10,000

1 GRAND PRIZE: TWO WEEKS IN EUROPE FOR TWO

All expenses paid. British Overseas Airways Corporation, one of the world's largest and most experienced jet airlines, has been selected to fly you across the Atlantic. BOAC's 707 Intercontinental flies New York to London the fastest way, in only six hours and 20 minutes. You will have a full 14 days in Europe. Arrangements will be made to have the winner visit leading medical institutions and meet some of Europe's foremost physicians.

2 SECOND PRIZE: NEW BRITISH TRIUMPH SEDAN

The new Triumph/Herald has won world-wide acclaim and was selected as the car with the most wanted features for the hospital staff physician. It sets a new standard for safety, economy, service and ease of handling. Four-wheel independent suspension makes it almost impossible to turn over—over-sized brakes—steering column that telescopes in case of emergency—never needs an ordinary "grease job"—up to 40 miles per gallon.



Resident Physician

IN PRIZES

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Plus five prizes of $100 each; ten prizes of $50 each; and 100 prizes of $25 each. A total of 120 chances to win! Your chances are excellent—since only residents and interns are eligible.

It Pays to Read . . .

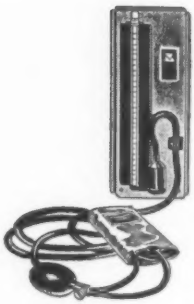
Remember, contest questions will be compiled from material appearing in current medical journals (those published on and after April 1, 1960). So start reading! Contest rules will appear in next month's RESIDENT PHYSICIAN.

Mediquiz Contest

Contest starts in August issue

Equipping an Offi

What equipment is needed by the generalist who is completing his residency and preparing to open an office? RESIDENT PHYSICIAN *recently put this question before a number of practicing GPs. Based on their experience, this article is presented as a general guide for those residents who will soon be equipping their own offices for general practice.*



General practice is concerned with all members of the family, young and old alike. And when considering equipment for his office of "family medicine," the physician must remember that his practice may include pediatrics, geriatrics, internal medicine, allergy, preventive medicine, dermatology, public health, rehabilitation, psychiatry, and to varying degrees, obstetrics and office surgery.

Equipment needs will depend in part upon the proximity of hospitals and diagnostic centers, and

an Office for General Practice

The general practice of medicine can include elements of nearly all specialties. However, there is a rapidly growing trend for the generalist to emphasize one or another of the special areas of medicine, according to his inclination, training and practice location.

the GP's relationship with consultants.

Since this article is based on a survey made of general practitioners from many different sections of the country, we will describe an office suitable to average needs.

Waiting room

In planning your waiting room, keep in mind that your practice will accommodate both children and adults, from newborn to the aged.

In general, physicians surveyed by RESIDENT PHYSICIAN advise: *"Keep your waiting room soothing, functional . . . not luxurious."*

Carpeting is not necessary. A rainy day, a dozen children with muddy feet, and the impracticability of carpeting becomes obvious.

Also, carpets aren't inexpensive—to buy or to keep clean.

A colorful, composition tile or linoleum in the waiting room looks fine, stands abuse, and is relatively easy to maintain, according to most GPs. And too, if desired, there is a wide variety of patterns and colors from which to choose, and at prices which won't break your limited budget.

The cost is perhaps a third of that for a carpet. An average room can be covered with an attractive tile or linoleum for $75.

Nonskid throw rugs will add pleasant accents to the room at only a small additional expense.

Office equipment you'll need in beginning private practice

This is the second in a series of exclusive articles on equipping your office for the private practice of your specialty. Recommendations are based on a survey conducted by your journal among practicing specialists.

Prices quoted are approximate and represent new equipment unless stated to the contrary. When a wide range of price and quality is available for a specific item, this fact is indicated.

In addition to equipment items, the surveyed specialists provided important information concerning office layout, furnishings, and the relative importance of various items of office equipment—to help you in planning and selecting your future equipment purchases.

Two types of chairs can be used to advantage: chairs for the parents and smaller chairs for children.

Adult chairs should be comfortable but strong. (While intended for the parents, they will frequently be occupied by the mother and her offspring—at the same time.)

Safety, of course, is important. Sturdy chairs which won't tip over easily, smooth arms and legs, without projecting decorations, are features to look for.

Plastic-covered wooden chairs are a good choice. Reasonably comfortable, they come in attractive colors and are washable. They can be purchased as separate units, with or without arms, or in units of two or three matching pieces to make a functional couch arrangement. Chairs of this type cost from $25 to $40 each.

Since the average waiting room of the physicians consulted had chairs for six adults, you can estimate a cost of from $150 to $200 for adult chairs.

Children's chairs are smaller and less expensive. Not recommended were rocking chairs and folding stools. Sturdy wooden benches of the footstool-type or standard hardwood captain's chairs for tots run from $8 to

$15. These can be kept fit by spray-painting with bright enamel in various colors. Though many general practitioners reported you should have as many juvenile chairs in the waiting room as there are chairs for adults, most didn't have this many.

Magazines

The family physician's office will have magazines for parents and magazines for children. By placing adult magazines on wall racks above the children's reach, many physicians get better mileage from these periodicals.

"Sloppy, dog-eared magazines strewn around your waiting room make an extremely poor impression," reported one of our consultants, "and it's amazing how few physicians seem to realize it!"

Wall racks can be built by you or a local carpenter for less than $25. Manufactured racks are priced in the neighborhood of $10 to $40, depending on the quality.

Children's magazines can be placed on a low level, in play boxes along a wall or on sturdy magazine tables.

Floor lamps and children don't get along. Table lamps are easily toppled. A good suggestion is to have most of the lighting from ceiling or wall fixtures. These lights can be attractive, cheap, give good reading light, and more important, they can't be tipped or broken easily. Prices vary, but good-looking lamps for wall use can be purchased for $6 to $20.

If you want table lamps, GPs advise: "keep them safe and simple."

There should be no glass to break and cause injury to your patients. Ornate lamp shades will quickly be damaged, adding nothing to the room except disorder and extra dust to bother allergic patients.

One ex-navy GP reported: "When you consider that kids are active, curious, quick and not up on 'cause and effect' physics, you'll find the best office is one which is like a ship, battened down and ready to ride out a big blow."

Play area

Some GPs recommended a special play area for children within the waiting room itself. This can be arranged so as to keep children from annoying adults, and at the same time give the children some occupation while they are waiting. A corner of the main waiting room equipped with a play box and toys is adequate. A small room

off the main waiting room is not recommended. (Lack of supervision often results in an impossible noise situation, as well as an increased potential for accidents.)

Expense can be kept down by the purchase of a children's play box for $10-$20 and another $10 for a few toys.

Toys, of course, should be purchased with safety in mind. Riding toys that may collapse and injure the child should be avoided. Toys having many small parts which can be swallowed or get under a child's feet should also be avoided. The best and cheapest toys are washable plastic, stuffed animals; reading games and story books for older children.

Consultation room

The consultation room is, for the general practitioner, as for most specialists, a most important room in his office. Here the doctor and patient first meet. Here the history is taken and the first interview is often lengthy. Most GPs indicated that this room should contain some of the "extra niceties" in decor. The consensus of opinion was that a carpet is an important addition (although not an absolute necessity).

A desk, of course, is needed, the price depending on your choice of style, size and material. Average price paid for a desk, according to our survey, was $150. But figures ranged from $50 all the way to $500. One point: the desk should be large enough, and contain enough drawer space for some of the hundreds of items you will want "at your fingertips."

Comfort

Your chair should be picked primarily for comfort. It will be your close associate for many years. Try before you buy. Good

chairs can be expensive. According to physicians, the chair they thought "best," in some cases, cost as much as $250, but average price was $80.

The patient's chair should also be chosen for comfort—the comfort of the *average* individual.

Our respondents indicated a cost of $50 to $75.

One other chair may be necessary for the friend or relative of the patient.

Bookcase, cabinet

In choosing a desk lamp, care should be given that the light is reflected down, not into the patient's eyes. A good desk lamp may cost from $25 to $50.

A bookcase in the consultation room was favored by most GPs. Depending on whether you choose standard units or custom-built to fit odd-sized wall areas, prices vary from $40 to $150.

A cabinet was thought useful in the consultation room (if there is space enough without crowding). Prices run from $50 to $75.

Examining room

Most general practitioners queried bought examining room equipment in sets of four or five pieces; that is, an examining table, a treatment cabinet, a treat-

"... What? No, that was just my aide walking into the new partitions. She hasn't quite gotten used to them yet."

ment stand, a stool, and a sanitary can. Prices vary according to the type of equipment purchased, the materials, and the manufacturer. In general, a set bought new can cost as little as $500 or as much as $1,000 or more.

Cabinet, stand

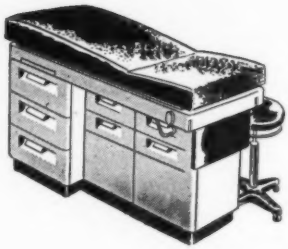
A treatment cabinet and a treatment stand may not be necessary right away. Perhaps money could be saved by using wall shelves or built in cabinets to serve the same purpose. In either case, most general practitioners reported they paid less than $75 for a treatment stand and a similar price for the treatment cabinet.

Examining lamps vary from as little as $15 to as much as $260 and more; the difference depending upon the source of light, type of illumination, size and quality.

A small sturdy stool for mounting the examining table should cost no more than $15 to $20, but make sure it's as slip-proof as possible.

Table

A good examining table can be purchased new from $250 to $800. The difference in price reflects the type of materials, decorations, and extra features provided. Some beginning general



practitioners buy an examining table second hand. Such a table in good condition can be obtained for about $100, and an adequate refinishing will cost $25 to $30.

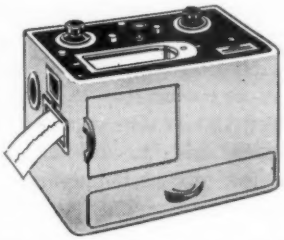
Second table

A second examining table for children is advisable, according to many GPs. A commercial table can be purchased new in a medical supply house for prices from $250 to $450.

The more elaborate and expensive tables have built-in scales and measuring devices. The beginning general practitioner might better do without these deluxe models if budget is squeezed. A kitchen supply house will build a table to your directions and specifications as to height and width for about $150. It can be brush-painted or sprayed in any desired color. The mat will be extra.

EKG

The electrocardiograph is "an important item of equipment" needed by the generalist, according to 60% of those polled. Most felt it should be purchased new. "This will be one of your best friends in practice," and, "it is one thing that will pay for itself in the first year or so," are typical comments on the EKG.



Prices of the electrocardiograph vary according to design and type. About $600 is an average price.

BMR

On the question of basal metabolism equipment, general practitioners polled were split. About half felt BMR equipment was necessary at the beginning. The other 50% stated that they thought it could be postponed for at least a year or two.

In general, if the additional expense is not too great a burden, the equipment should be purchased at the beginning, since it is an important aid in diagnosis. The added income would probably make the initial expense worthwhile. Prices range from $400 to $700.

X-ray, fluoroscope

Whether or not you need x-ray equipment or a fluoroscope immediately is a debatable point. Twenty-two percent of the physicians queried felt an x-ray machine was necessary even in the *beginning* practice. However, nearly 65% felt that a fluoroscope is required. A used fluoroscope can be bought for from $550 to $800. Of course, as with any used equipment, price is not as important as the good reputation of the seller. A guarantee on the tube is a minimum requirement.

New fluoroscopes are available at prices from $1200 up.

A new x-ray machine will cost anywhere from $1,200 to $12,000. The wide price range indicates the many variations in size and ampere capacity of x-ray equipment. The prices of 100 MA machines start at $3,000.

If your future office is to be separated from your home, plan on having a refrigerator for your office. The type is not as important as the size. In general, the price of a new refrigerator will

run from $100 to $250 depending on the style and volume of storage provided. A refrigerator should be of sufficient capacity to store your requirements of antibiotics and medicinals.

Sterilizer

A diathermy machine was considered an immediate necessity by 40% of the physicians surveyed—however, here again, expense was a factor.

A sterilizer or autoclave is a must, according to 100% of the survey group. The majority felt it should be bought new, since the price of a sterilizer (cast-bronze boiler, chrome exterior: $60 to $100 depending on the size) is relatively small compared to the possibility of faulty electrical circuits in a used machine. Many recommended autoclaves; prices from $220 to $500, new.

An adult scale should be purchased, price: about $60. An infant's scale, cost about $40, will also be needed.

Other special instruments needed in the beginning practice of the general practitioner include ophthalmoscope, proctoscope, sigmoidoscope, sphygmomanometer, otoscope, etc.

Most residents have purchased some of these items at some time during their career.

Many GPs use electric cautery in their office. Such an apparatus may vary in price from $90 to $350.

Dressing room

Since your dressing room and lavatory are used frequently, special care should be taken in furnishing them (and keeping them immaculate at all times).

The dressing room should be separate from the lavatory and adjacent to the examining room. It should be well lighted, have a chair and a mirror. Hangers or hooks should be supplied for clothing and gowns. Cost of dressing room equipment is usually less than $75.

The lavatory, aside from being readily accessible to waiting room and examining room, should contain a wash bowl, stool, a mirror, shelf, waste basket, soap and towels. Your nurse will have access to sanitary items and will make these available to patients.

Other rooms

In many offices there is an extra room, a "utility room." It may consist of a small laboratory, a place to clean and sterilize instruments and gloves.

For the beginning practitioner, in order to cut down expense, it would probably be wise to ac-

cumulate laboratory equipment gradually instead of trying to get everything immediately. You should, of course, have equipment sufficient for doing complete blood count, urinalysis, and sedimentation rate. The cost is small when compared with the income derived. A used microscope can be purchased from $175 to $350. New microscopes run from $250 to $550.

Other equipment needed for these tests can be purchased for no more than $65 or $75.

A centrifuge will also be necessary. Be sure it has sufficient speed to do an accurate hematocrit since hematocrits and urines will constitute your primary need for a centrifuge.

Photoelectric colorimeters and other equipment to do blood sugars and other detailed blood studies are very useful and can greatly increase income for the beginning practice. Thirty per cent of the survey group stated that they had such equipment, although many did not complete their purchases until the second year of practice.

In an attempt to give an overall view of the cost of the outfitting the beginning office in general practice, many items have been omitted. Many offices can be (and are) much more elaborately equipped.

Also, special consideration was given to price. In modern day merchandising, credit terms can be made so attractive to the young physician that in many cases it may be wiser to purchase an item now, on credit, rather than to defer it. This would apply primarily to equipment items which produce income equal to or greater than the installment payments.

Approximate cost

We asked each member of the survey group to give an approximate figure for the cost of outfitting his original office. The figure was to be complete, including any items such as typewriters, nurse's desk, nurse's chair, filing cabinets, etc.—some of which you may be able to do without.

About 20% of the GPs surveyed by RESIDENT PHYSICIAN outfitted their offices for under $3,000. More than half spent $3,000 to $5,000 on their initial office equipment. Another 20% stated that their offices cost between $5,000 and $6,000, and 5% reported total cost of equipment exceeded $6,000.

On the average, based on these figures, offices for the beginning general practitioner can be equipped for under $5,000.

John C. Leonard, M.D.

Guest Editorial

The Old vs The New

When we compare the opinions of writers of the past with those of the present, we will always find the Jeremiahs, the calamity prophets whose view of the future is so well expressed in the pessimistic question, "What is this younger generation coming to?" Those who are young often have a conviction, expressed or unexpressed, that there is little or nothing of the old that is good. Per contra, the elderly are likely to look back to the "good old days" with increasing blindness for and decreasing appreciation of the good and helpful aspects of their modern environment.

Fitting the above thoughts to a problem of great importance, one is impressed with the frequency with which physicians above the age of forty or fifty years express alarm regarding the "nine to five" attitude which seems characteristic of so many of today's young physicians, both at the house staff and the junior physician level. It is apparent that as ever greater numbers of our future physicians are recruited from homes where attitudes toward "rights" and "benefits" have been pre-eminent over attitudes toward "responsibilities," this problem will increase. Should they continue to increase, qualitatively and quantitatively, these attitudes emphasizing rights rather than responsibilities are certain to re-

JOHN C. LEONARD
Director of
Medical Education,
Hartford Hospital

sult in a decrease of the respect in which our profession has been held by the public. The professional man, particularly the physician, *cannot command respect; he must earn respect*. Such respect can only be earned by the physician, be he house staff or privately practicing physician, who is willing to serve his patients, his community and his profession in a manner that is "beyond the call of duty."

We older physicians are pleased and deeply gratified to see how much more adequately today's house officers are compensated in salary and living quarters, in teaching and in guidance than were we. Certainly physicians, just as other human beings, can become physically and emotionally fatigued. Physicians should and must have time for family and for recreation, but not to the point of neglect of their chosen profession.

We, as a profession, make up but a small percent of the total population of our land. Quantitatively, we can carry little weight in our attempts to assist in guiding our country through the present period of socio-economic evolution, of which medicine and medical care are such a very important part. Qualitatively, however, if we can adopt of the new those things which will increase further our health value to our patients, and cling avidly to the unselfish professional attitude of our medical past, then we shall not be found inadequate by our patients, our community of our profession. All that is *old* is not bad; neither is all that is *new* totally good.

HARTFORD HOSPITAL

Located in Connecticut's capital, Hartford Hospital combines community service with postgraduate teaching programs. Averaging 36,000 admissions yearly, the hospital provides board approved training in eight specialties and a two-year rotating internship

one of a series on leading resident-intern centers

Hartford Hospital is a voluntary nonprofit institution which combines community service with teaching and research programs.

Located in Hartford, Connecticut's capital, the hospital has 847 beds and 150 bassinets, and each year averages some 36,000 admissions.

The main building is a 14-story structure completed in 1948 at the cost of $10 million. Adjoining are a six-story obstetrical wing and a medical building of eight stories which provides private offices for staff members.

Other units provide residences for house staff, student nurses, staff nurses and nursing school faculty, a house for elderly people, and a hospital for convalescents.

Contemplated additions to these facilities are new buildings for the school of nursing, a new house for the aged and quarters for married house staff members.

Training

Postgraduate training includes a two-year rotating internship program (the second year of which is acceptable for the specialty boards as part of residency training in internal medicine or general surgery), and fully ap-

proved residencies in general surgery, internal medicine, anesthesiology, pathology, pediatrics, radiology, and obstetrics and gynecology. In addition, the department of neurosurgery provides a full residency in conjunction with the neurosurgical service at Grace-New Haven Community Hospital (Yale University).

Graduate education at Hartford functions under the guidance of the Graduate Medicine Committee of the Staff, the secretary of which is the full-time director of medical education. The director of medical education plans the program of services for interns as well as meetings and conferences, and works with members of the house staff on an individual and group basis.

Medicine

The three year medical residency program is arranged on a pyramidal basis with a group that usually numbers around 24, depending on changes caused by call to military service. There is a progressive increase in responsibility, culminating in a senior year which demands a high clinical and administrative ability.

The first year of training (junior assistant residency) follows one year of internship at Hartford Hospital or elsewhere,

Volume and variety of experience is available to residents on the Emergency Service.

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99.5% of isolates (214 of 215) from patients with staphylococcal infections—including many antibiotic-resistant strains—proved sensitive in vitro to ALTAFUR in tests conducted across the nation.[3] **99.7%** of staphylococcal isolates (334 of 335) at a large general hospital—including many antibiotic-resistant strains—proved sensitive in vitro to ALTAFUR.[4]

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"Because of its relationship to previously developed nitrofurans, it is anticipated that [ALTAFUR] will retain its original spectrum after longstanding clinical usage."[5] Development of significant bacterial resistance to ALTAFUR has not been encountered to date.[6]

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Side effects are easily avoided or minimized by these simple precautions: 1) *alcohol should not be ingested in any form, medicinal or beverage, during* ALTAFUR *therapy and for one week thereafter* 2) each dose should be taken with or just after meals, and with food or milk at bedtime (to reduce the likelihood of occasional nausea and emesis).

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1. Weiner, A. L.: Paper presented at the Conference on Recent Advances in the Treatment of Chronic Dermatoses, University of Cincinnati (Ohio), Nov. 5, 1959. 2. Compiled by the Medical Department, Eaton Laboratories, from case histories received. 3. Christenson, P. J., and Tracy, C. H.: Current Therapeutic Research **2**:22, 1960. 4. Glas, W. W., and Britt, E. M.: Proceedings of the Detroit Symposium on Antibacterial Therapy, Michigan and Wayne County Academies of General Practice, Detroit, Sept. 1, 1959, p. 14. 5. Leming, B. H., Jr.: Ibid., p. 22. 6. Investigators' reports to the Medical Department, Eaton Laboratories.

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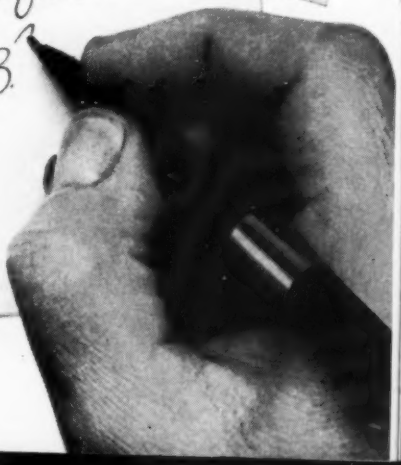
Sig: 1 tab q.i.d. c̄ food or milk

R.B.



Hartford Hospital, voluntary and nonprofit, combines community service, teaching and research.

and consists of the following assignments: ward medical service, admissions officer, medical service at Newington Veterans Hospital, private medical service, neurological and psychiatric services. This year may complete the second year of the two-year internship contract and it is a prerequisite (or its equivalent elsewhere) to the assistant residency.

The second year (assistant residency) accentuates the accumulation of specialized knowledge and techniques in internal medicine. In general, assignments are made to each of these four services: cardiology and gastroenterology; pathology; medical service, Newington Veterans Hospital; outpatient service.

A group of three third-year residents (chief residents) are given a rotation through three major responsibilities.

- Consultation service and resident in charge of ward medical service. This includes daily rounds, fulfilling requests for consultation from other services, coordinating house staff participation in clinical work under the direction of the chief and the coordinator of the medical department.
- Outpatient diagnostic clinic. Supervises all house staff in their assignment to this service under the direction of the full time clinic director. Participates in nursing school lectures.
- Chief medical resident, Newington Veterans Hospital. Supervises the work of junior assistant and assistant residents under the direction of the chief of service at that hospital. Coordinates participation of residents in teaching rounds and clinics at Newington and Hartford Hospitals.

Slides and sections are a part of residents' careful training in pathology.

House staff clinical instruction is centered on all-important bedside rounds.

ASSISTANCE FUND

A fund to assist "outstanding" applicants is available at Hartford Hospital. Established in memory of Mr. George N. P. Mead, the fund's purpose is to "aid through loans outstanding medical school graduates with inadequate means to serve as Interns or as Residents at the Hartford Hospital, and to aid them after graduation . . . in establishing themselves in private practice. . . ." The control of the fund is vested in a committee composed of three members of the professional staff of the Hartford Hospital and two lay members. Application is made to the chairman of the Mead Fund Committee.

Surgical

The surgical residency was established following World War II, with emphasis on broad training for the surgeon who will practice in the small urban community. The program has continued to grow in statute with an expansion of facilities to further this original aim.

A dwindling ward service has become an increasingly serious problem to most surgical residencies. At Hartford this problem was anticipated and met in two ways. First, all semiprivate surgery was allocated to the ward floor and is available for teaching purposes.

Second, the available ward beds have been increased: by furnishing the resident staff in surgery to the Rocky Hill (Connecticut State) Veterans Hospital, and by the Hartford Hospital staff sponsoring and supervising the surgical program at the U.S. Veterans Hospital at Newington, where an active surgical service has been in existence for 24 years.

Out of a total of approximately 20,000 operations at Hartford Hospital, over 6,000 general surgical procedures are performed each year. The ward surgical volume is composed of about 600 operations at Hartford Hospital, over 250 at Rocky Hill, and over 500 at Newington.

Cancer surgery

From the inception of the program, the best assistant resident, senior level, has been chosen to be sent to Memorial Hospital in New York City for training in cancer surgery. The physician chosen has the benefit of a $1200 fellowship from the Connecticut Cancer Society in addition to the stipend from Memorial Hospital.

In Acute Illness...

NILEVAR®

Can Speed Recovery

"Commonly, negative nitrogen balance[1] occurs during acute febrile illness and following traumatic events and surgical procedures." When this negative balance is considerable and persistent, convalescence[1] is delayed.

Nilevar Builds Protein, Speeds Convalescence to Complete Recovery[2-5]

By reversing negative nitrogen balance, Nilevar[3] improves appetite and increases the sense of well-being and may be expected to shorten convalescence and illness.

Goldfarb and his associates[2] state: ". . . we were impressed with the efficacy of Nilevar as an anabolic agent. All the patients reported feeling much more vigorous and experiencing an increase in appetite. . . ."

An initial daily dosage of 30 mg. of Nilevar (brand of norethandrolone) is suggested. After one to two weeks, this dosage may be reduced to 10 or 20 mg. daily in accordance with the response of the patient. Continuous courses of therapy should not exceed three months, but may be repeated after rest periods of one month. Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil with benzyl alcohol.

1. Eisen, H. N., and Tabachnick, M.: Protein Metabolism, M. Clin. North America 39:863 (May) 1955. 2. Goldfarb, A. F.; Napp, E. E.; Stone, M. L.; Zuckerman, M. B., and Simon, J.: The Anabolic Effects of Norethandrolone, a 19-Nortestosterone Derivative, Obst. & Gynec. 11:454 (April) 1958. 3. Batson, R.: Investigator's Report, Feb. 11, 1956. 4. Weston, R. E.; Isaacs, M. C.; Rosenblum, R.; Gibbons, D. M., and Grossman, J.: Metabolic Effects of an Anabolic Steroid, 17-Alpha-Ethyl-17-Hydroxy-Norandrostenone, in Human Subjects, J. Clin. Invest. 35:744 (June) 1956. 5. Brown, C. H.: The Treatment of Acute and Chronic Ulcerative Colitis, Am. Pract. & Digest Treat. 9:405 (March) 1958.

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Research in the Service of Medicine

RESIDENCY POSITIONS

	FIRST YEAR	SECOND YEAR	THIRD YEAR	FOURTH YEAR
SURGERY	8	4	4	4
MEDICINE	16	8	4	—
OB-GYN	1	1	1	—
PEDIATRICS	1	1	—	—
PATHOLOGY	2	2	1	—
RADIOLOGY	1	1	1	—
NEUROSURGERY	2	2	2	—
ANESTHESIOLOGY	10	10	10	—

Under the direction of the director of medical education, an extensive hospital educational program has been developed, and surgical teaching has been expanded. In addition to instructing at the operating table and at daily disposition rounds, formal teaching rounds are held Monday through Friday from 4:30 to 5:30 P.M. The weekly surgical clinic is presented by the resident staff each Saturday morning in the amphitheater.

Surgical privileges at the Hartford Hospital require board certification or its equivalent and no assistants are allowed in the operating rooms without these privileges, with the exception of the resident staff. License to practice in the state of Connecticut is *required* for all residents.

Thoracic surgery, and proctology are included in the general surgical residency.

Attendings

The surgical attending staff represents a broad cross-section of surgical practice, reflecting their residency training in many centers, including: The Barnes Hospital, St. Louis; Lahey Clinic, Boston; Massachusetts General Hospital, Boston; Memorial Hospital, New York, Presbyterian Hospital, New York; Hartford Hospital.

The residency program is based on a modified pyramidal system with four years of surgical training after an accredited internship. The aim is to split off unsuitable candidates early and carry the deserving through

off to a good day—constipation relieved

Pleasant-tasting Agoral is the laxative virtually tailor-made for busy people. Taken at bedtime, Agoral works effectively and gently overnight, without disturbing sleep, to produce a normal bowel movement the next morning—*before* the day's activities begin.

agoral®

the gentle laxative

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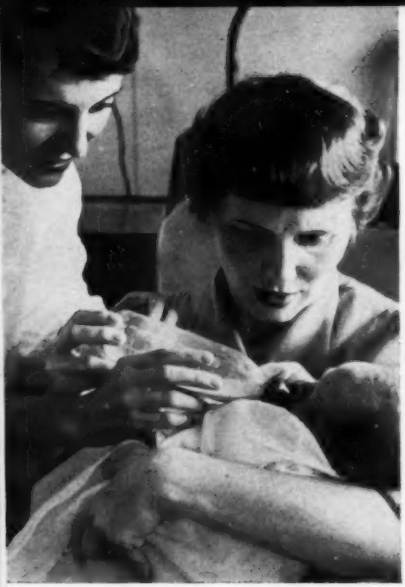

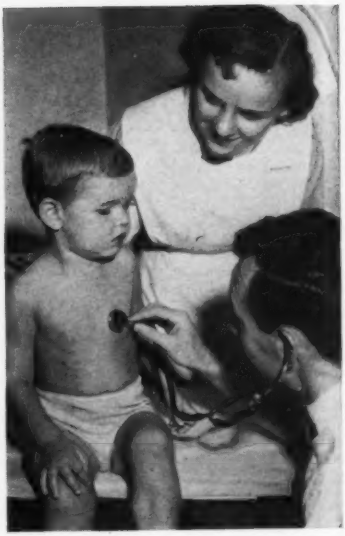

Pediatric residents are kept busy caring for newborn, plus a broad range of medical problems from infancy to adolescence.

to accreditation. Thus far this policy has been successful. The entire surgical residency program is approved by the American Board of Surgery and the American College of Surgeons.

Research facilities at the hospital show how a nonuniversity affiliated institution can supplement its training program in order to adequately perform its roll in medical education. At Hartford, special laboratories have been established to implement research in the areas of cardiopulmonary physiology, liver biochemistry, open heart surgery, anesthesiology, and others, making a total of 22 projects currently under investigation.

Postoperative recovery rooms and the emergency treatment unit are staffed by a special group and, like the blood bank, are operative 24 hours each day. Two variable temperature and humidity rooms are used for therapy and study of hypothermia.

for enhanced surgical analgesia—

meperidine-promethazine combined

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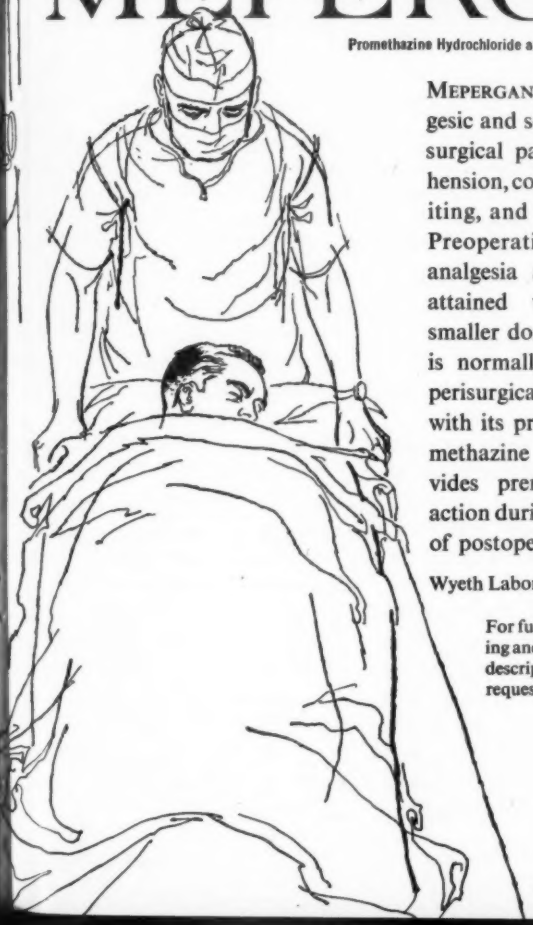
Promethazine Hydrochloride and Meperidine Hydrochloride, Wyeth



MEPERGAN provides both analgesic and sedative benefits for the surgical patient. It allays apprehension, controls nausea and vomiting, and facilitates anesthesia. Preoperative and postoperative analgesia and sedation may be attained with a considerably smaller dose of the narcotic than is normally used. For inclusive perisurgical care, MEPERGAN—with its proved 1:1 ratio of promethazine to meperidine—provides premedication, anesthetic action during surgery, and control of postoperative pain.

Wyeth Laboratories Philadelphia 1, Pa.

For further information on prescribing and administering MEPERGAN see descriptive literature, available on request.

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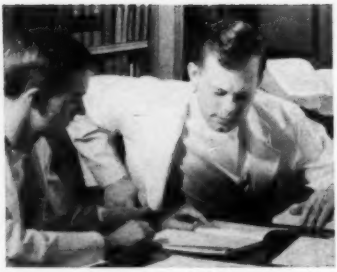
A Century of Service to Medicine



Medical library plays vital role in house staff training.

The Hartford Medical Library contains approximately 100 journals and more than 800 up-to-date texts. It also can draw upon the resources of the Hartford Medical Society Library and Yale University. A full-time librarian is on duty.

Clinic

A complete diagnostic clinic with a full time director provides a valuable teaching service in outpatient medicine and in following service cases after their discharge.

As in most voluntary hospitals, patients are admitted to private, semiprivate or ward services. Because prepayment plans have in recent years reduced the number of patients admitted on ward service, the medical staff at Hartford has put into operation a plan whereby all semiprivate patients are included in the teaching program.

Full maintenance (including room, board, non-toll telephone, uniforms and laundry) is provided for all house officers. Though there are no facilities provided for families of house officers, residents are assisted in the location of housing in the Hartford area.

In addition to maintenance, a cash stipend is provided as follows: interns, $100 per month; junior assistant residents, $125; assistant residents, $175; residents, $225. Senior fourth year surgical residents receive $250 per month. Two weeks' vacation for each year of service is allowed all members of the house staff above the first year intern level.

All residents are required to avail themselves of medical liability insurance. Assistant residents are also advised to secure this coverage.

Application for residency training should be made to the Director of Medical Education, Hartford Hospital, 80 Seymour Street, Hartford 15, Connecticut. Physicians interested in training in anesthesiology should write directly to The Director, Department of Anesthesiology, Hartford Hospital.

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BALTIMORE BIOLOGICAL LABORATORY, INC., Baltimore, Maryland—

A vigorous young company, BBL and its division, Cappel Laboratories of West Chester, Pennsylvania, offer one of the fullest available lines of culture media and diagnostic reagents, as well as laboratory equipment and apparatus.

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An intimate knowledge of surgeons' needs for truly sharp cutting instruments—and the technical knowledge and skill to meet those needs—led to the development of the first detachable blade by this longtime leader in the manufacture of surgeons' knives.

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Semi-Socialized Medicine in Germany

This system, with its disadvantages to patient and doctor, is supported by the people. Why? Because, says the author, the people don't really know what they are losing in quality medical care.

Karl A. Dresen, M.D.

When in the year of 1870, Bismarck introduced the law which instituted the "Krankenkasse" (sick care) thousands of workers hailed him as the true Samaritan who took care of the needy. The government had created an insurance company which would take care of the low paid working classes and their families through physicians' care, medication, hospitalization, and disability income.

Physicians were also happy about this law because in those days the average general practitioner would only bill his patients once a year, and in many rural districts it was customary for patients to pay what they thought to be adequate as the physician's remuneration.

Under the new plan, the doctor no longer had to worry about billing and how to scale billing up for richer patients, down for the poor. He gladly gave up his privilege of charging. Now, he reasoned, the government would do all the worrying and give him more time for his patients.

Fixed fees

Private medical insurance holders whose income level brought them into "Krankenkasse," soon dropped their private coverage. In order to have a uniform fee system throughout the country, physicians' fees and

fees for surgical procedures were fixed by the government and tabulated in the "Preussische Gebuehrenordnung" (Preugo).

Deductions

Without essential changes the original system is still applied today. Due to the increased standard of living and the increased cost of living, the upper limit for the so-called low income group is set at $600 a month, which means that everybody on salary up to $600 a month automatically belongs to the "Krankenkasse." (All money comparisons in this paper are based on comparable U. S. purchasing power.)

Dues are usually deducted before the worker receives his pay check. And since the worker has no influence on the rates, he considers the deduction as something inevitable—like taxes. Therefore, he disregards the deductions and begins to think of governmental care as free care—and for him exclusively.

When the "Krankenkasse" participant, or a member of his family, feels sick, he simply asks his employer for a "sick-slip" (Krankenschein). This allows him to choose a physician and be under his medical care for three months. No money exchange is involved in obtaining the slip or in going to the physician. There are no bills. Prescriptions are honored at the pharmacies for a nominal charge of 25 cents regardless of the cost of the prescription.

Advantages

Further advantages for the insured are that as long as the patient is sick, and therefore unable to work, all his dues to the insurance company are automatically suspended.

Sick pay, up to 90 percent of net income, starts on the third day of his sickness. In the event the illness lasts longer than 14 working days, back payment is made for the first two days not honored originally. This naturally leads to "extended" illnesses in order to obtain the pay for the first two sick days. Since house calls are free and physicians' waiting rooms are often overcrowded, easy advantage is taken of this opportunity.

Hospital

Hospitalizations are sometimes a bit more troublesome since it is the patient's responsibility to find an empty hospital bed and then to take the physician's referral slip to the hospital authorities to be admitted. Cheating is easy and hospitals are always crowded, which produces a de-

lay — even in the admission of true emergency cases. All hospitals have closed staffs and the family physician is not permitted to treat his patients inside the institutions. However, the patient will be referred back to his practitioner. The hospital staff is not permitted to practice outside the hospital.

The average insured, and that means the majority of voters, is quite content with this system. He can get medical care any time he likes it, "free of charge," and without undue difficulties.

Government

The system is termed *semi-socialized* because theoretically everyone has the opportunity to make private insurance arrangements; however, as pointed out before, it would be wasted money.

An income of $600 a month is a substantial income in Germany. Furthermore, opportunity is given to any employee to voluntarily remain within this governmental insurance even if he moves into a higher income group. It is readily understandable that 86 percent of the population have governmental insurance. Approximately 10 percent are privately insured and 4 percent are not insured at all.

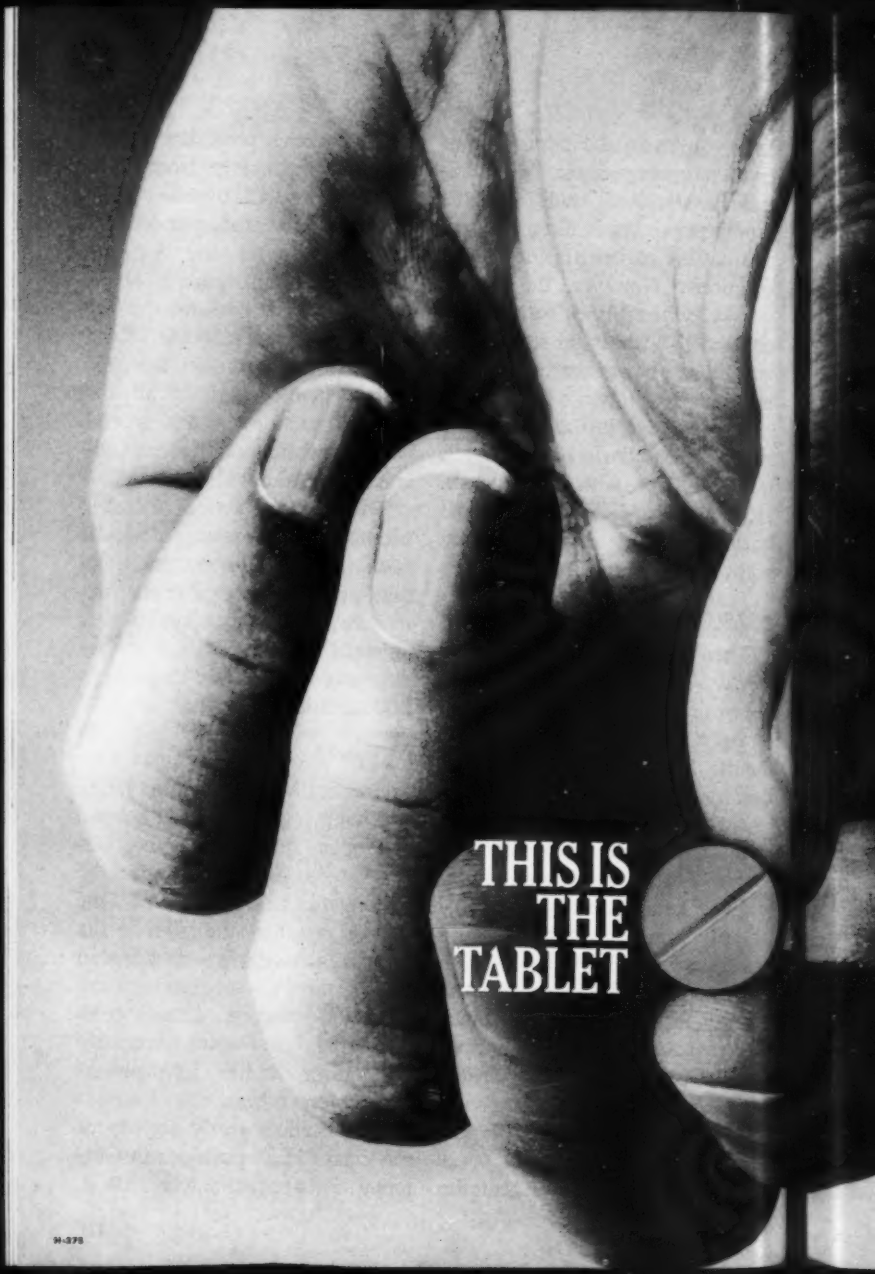
From these figures it can be seen that the physician obtains his income mostly from those who are insured by the "Krankenkasse." If the physician is not very famous and does not draw from the 10 percent of privately insured patients, he will need the patients of the "Krankenkasse" to maintain his practice. Therefore, practically all general practitioners and specialists in private practice are affiliated with the "Krankenkasse."

The "Krankenkasse" distributes appointments on a ratio system. This ratio was one thousand people to one physician until two years ago when it was changed to 600:1. Attempts are currently being made to create a 500:1 ratio.

Affiliation

Practically speaking, a young physician is unable to settle down and open up his own office unless he has a contract with the "Krankenkasse." In 1958 the average age for admission to the "Krankenkasse" as an affiliated doctor was 45. Appointments are distributed according to a seniority plan in which veterans, refugees or the like, have preference before others.

The needed yearly supply of physicians in all positions in Germany is approximately 1,300.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ALPEN is the oral penicillin that provides, on a fasting stomach, peak antibiotic blood levels approximately twice as high as oral potassium penicillin V... and significantly higher than I. M. penicillin G.

Some strains of staphylococci resistant to other penicillins exhibit in vitro sensitivity to potassium phenethicillin.

ALPEN has greater freedom from the G. I. sequelae (overgrowth of resistant flora) sometimes observed with broad spectrum-mycins.

ALPEN gives much higher antibiotic levels within the first hour of ingestion by the well-tolerated oral route.

WHEN TO USE ALPEN Recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci.

HOW TO USE ALPEN Depending on the severity of the infection, 125 mg. (200,000 units) or 250 mg. (400,000 units) three times daily may be used. In more severe or stubborn infections, a dosage of 500 mg. (800,000 units) t.i.d. may be employed. In beta hemolytic streptococcal infections, treatment should be continued for at least ten days.

PRECAUTIONS The usual precautions in the administration of oral penicillin should be observed. For further details see package literature.

Tablets: 125 mg. and 250 mg., bottles of 25 and 100.
Powder for Oral Solution (lemon-lime flavored), 1.5 Gm. bottle (125 mg. per 5 cc. teaspoonful).

this is the tablet that gives higher peak antibiotic blood levels

HIGHER THAN I. M. PENICILLIN G
HIGHER THAN POTASSIUM PENICILLIN V

ALPEN

ALPEN™—potassium phenethicillin

Schering

The "Krankenkasse" admits 500, but the output of the medical schools is in excess of 3,000. The rate of entry of refugee physicians from the Eastern zone into the Western zone amounts to approximately 300 yearly. As most of these are elderly physicians who were in practice before the arbitrary division of the country, most had contracts with the government insurance company. This meant that they were privileged in obtaining these contracts again. Therefore, a young physician must spend many years in residencies before he is finally able to settle down as a private practitioner. The knowledge accumulated during these residencies is only of limited value to him as practically all hospitals have closed staffs. Even treatment given at home is limited by insurance regulations.

Expenses

The money collected from the insured by the government insurance company goes first for the salaries and operational expenses of the "Krankenkasse." The rest of the money is distributed through a key system to the affiliated physicians. This means that the first 1,000 sick-slips are usually honored at approximately 100 percent of the set fee, the next 500 slips may be honored at approximately 50 percent and the following 250 may drop down as low as 25 percent of the set fee.

In epidemics, such as experienced during the flu in 1957, less money is coming into the insurance company as employees are freed of paying their dues during their sickness. Therefore, less money was distributed back to the physicians. This meant that during an average increase of the physician's work load of 20 percent, approximately 20 percent less than the average sums were paid out resulting in a 40 percent deficit not paid to the affiliated physician.

Increased costs

As the number of insured increased, operational costs and red tape of the insurance company also increased rapidly. While in one Western city, in 1904, six employees handled the load of a population of 85,000, in 1956 with a population of 110,000, some 56 employees were needed. This naturally also diminished the net pay to the affiliated physicians.

What is actually paid out to the physician?

Each sick-slip is nominally valued at $3.50 for each 3 month

NOW...triple sulfa vaginal therapy

in convenient tablet form

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Sultrin

TRADEMARK

triple sulfa vaginal tablets

for simplified control of vaginal infections...

"The clinical response obtained with the new vaginal tablet [SULTRIN] is comparable to that obtained with the same three sulfonamides in cream form. The vaginal discharge was rapidly controlled and the vaginitis and cervical erosions were cured in a high percentage of patients."*

One tablet intravaginally twice daily for 10 days. Course of treatment may be repeated if necessary.

Box of 20 tablets with vaginal applicator.

also available: Triple Sulfa Cream.† Large tube with or without applicator.

*Taleghany, P., and Heltai, A.: Am. J. Obst. & Gynec., in press.

Ortho

†TRADEMARK

period of taking care of one patient. This means that the patient can go to his physician or he can call him as often as he desires for the amount of $3.50 totally. This $3.50 figure is the 100 percent referred to above and actually drops very often to a lower figure when the distribution is made to affiliated physicians.

Fees for procedures carried out in the office are based on the "Preugo," created in 1870. Over the years these have been increased up to five times while the general cost of living has increased much more than that.

Flat rate

Simple procedures which are normally rated up to $10, are honored under the same flat rate of $3.50. This means that procedures such as physical examination and history, complete blood count, urinalysis, blood pressure taking, each being from $2 to $10, are not honored separately but are paid within the flat rate. These financial arrangements have not encouraged the physician to do these procedures very often, but rather skip them, or refer the patient to a specialist, especially as the referral brings the referring physician the same $3.50.

Minimum Rx

To make a living the physician is therefore obliged to have at least 4,000 sick-slips each year. This is a modest figure. Averaging three visits on each sick-slip, the physician would have 1,000 visits a month.

However, even this estimate is too low because of the special prescription policy under which the physician is obliged to work. He is permitted to prescribe only the minimum amount package or the smallest bottle manufactured. Manufacturers have even issued extra small packages for the benefit of the "Krankenkasse." These medications last from three to seven days; if there is chronic disease the patient must return each week.

This is especially troublesome for the older age group, many of whom are chronically ill. They return week after week, month after month to get their prescriptions filled; since many are retired, they have time to talk, and the doctor is put under the pressure of not delaying waiting patients through extended chats with the elderly patient.

A daily patient load of 100 to 120 patients is not unusual. This, in addition to house calls, gives the physician barely any time to improve or advance his studies.

Journal reading is greatly neglected. So is the physician's family life. Postgraduate courses are available but poorly attended. Reason: the physician must supply and pay his own locum tenans.

Care

As it is obviously impossible to examine 100 patients a day, patients are just not examined. It is not unusual that patients — even with lengthy diseases—have never undressed for an examination.

There are, however, a few patients who come to realize that they are not receiving the best possible medical care. They go to a so-called private physician, get his diagnosis and take his prescription to their "Krankenkasse" doctor. He copies the Rx, thus giving the patient a prescription paid for by the government.

No criticism

There is virtually no cooperation between the "Krankenkasse" and the physician. In any dispute the "Krankenkasse" will take the part of the patient. The physician's hands are tied and he cannot complain to the patient because this would be criticizing

the "Krankenkasse" and a reason for losing his contract.

For instance: Pregnant mothers receive $50 a week during the last 6 weeks prior to delivery. This amount is taken part from the employer and part from State funds. It is the physician's task to determine when those 6 weeks start. Especially in an obese multi-para it is difficult to determine the exact stage of gestation and to predetermine exactly the day of delivery.

The patient very often will cheat and give an earlier date than that of her first missed period. Any amount paid the patient above the $300 supposed to be paid is deducted not from the cheating patient, but from the physician who was unable to predetermine the exact date of birth.

If a patient forgets to bring in his sick-slip, and the doctor gives prescriptions to the patient, then not only the visit amount for the sick-slip will not be honored, but all money spent on prescriptions will be deducted from the doctor's income.

It is the "Krankenkasse" policy that it is up to the doctor to see that he gets his sick-slip. In practice this is not always possible, especially in minor emergencies, or if the patient has been with you for many years.

The doctor is not at all free in ordering those tests which he wants to order. Many physicians have a certain quota of x-rays. If this quota is surpassed, no matter how sick the next patient may be, money for x-rays will be deducted from the doctor's income.

Prescriptions

If the doctor wants to prescribe expensive drugs—and in the view of the "Krankenkasse," everything more than an aspirin is expensive—and he does so without specific permission of the "Krankenkasse," then it will be deducted from the doctor's income.

The doctor is constantly urged to prescribe the most *economical* drugs, which in the eyes of the "Krankenkasse" are the cheapest drugs.

Steroids can therefore only be ordered with the written permission of the "Krankenkasse."

Testosterone or other hormones are considered to be aphrodisiacs and also need special permission.

Yet, if the doctor tells the patient that he cannot order a particular prescription for him, and the patient happens to go to the "Krankenkasse" office, he will invariable be told that this is not so and that they will gladly give him the medication he needs and countersign his prescription. This

does not help to raise the patient's respect for the doctor.

Morale

The whole system brings about a deterioration of the morale of the patients and, finally, of the physician who is helpless against the demands of patients. It is common for the patient to look upon the physician as an employee.

The physician has to fill out endless forms for the insured. He has to state when the patient came to him and when he left. He has also to state whether or not the patient is sick enough to stay home and unable to go to work. Even the exact hours out of bed rest must be specified, for all his statements will be counterchecked by city employed physicians. Usually between 4 and 8 days after the family doctor has told the patient that he should stay home the patient will receive a postal card requiring him to go to a city physician to be rechecked to see whether or not it is still necessary for him to stay home. These state or city physicians are called "trust physicians" but actually they are distrustful physicians because they do not trust the judgment of the family doctor.

On the other hand faking a disease is easy since, as stated previously, most physicians do not have the time for thorough physical examinations.

Unethical practices

Some larger factories have adopted the system of giving one afternoon off a month if the employee should not feel well and in that way practice preventive medicine by sending him to a physician to be looked over. Soon the employee accepts this as a free afternoon. He may send his wife over to a physician to have the statement signed that he was in the physician's office. The patients seem to be totally unaware of the unethical procedure they have adopted, because they will threaten the physician that they will not bring their own or their children's sick-slips to him if he does not sign the statement.

Many physicians need the sick-slips. They may weaken and sign an obviously false statement. If the county medical society should learn of this false statement, the physician's license will be revoked.

Private patients, who often get a refund of only 80 percent of the doctor's bill from their private insurance company, will ask the physician to write a bill for

Baker's MODIFIED MILK POWDER

meets the special needs of premature infants

■ PROTEIN – ample protein, 80% greater than in breast milk (3.2 gm/kg in a 20 Cal/oz formula). ■ IRON – the addition of 7.5 mg/qt of formula assures an adequate supply of this important mineral. ■ MODIFIED FAT – the replacement of troublesome butterfat with coconut and corn oils results in improved tolerance. ■ ESSENTIAL LINOLEIC ACID – for most efficient use of calories (6% of the caloric intake). ■ MIXED CARBOHYDRATES – in quantities equal to breast milk levels minimize excessive fermentation. ■ VITAMINS – Recommended Daily Allowances of all essential vitamins. ■ SAFETY FACTOR – the Grade A* milk source minimizes chance of residual toxins.

The Baker Laboratories, Inc., Cleveland 15, Ohio

a 120 percent of the actual fee so that they are able to collect the full amount without digging into their own pockets. The sad thing about this is that physicians will agree in order to keep a private patient; the private patient represents cash to them.

Sacrifice of care

A semi-socialized system as it is being carried out in Germany appears excellent in the eyes of the patient. However, multiple restrictions by "Krankenkasse" on the affiliated physician, handicap him in the true fulfillment of his profession. He must sacrifice sound medical practice and frustrate his professional skill to comply with regulations, by-laws and directives of a lay organization, the "Krankenkasse."

He will not be able to render the best medical care to his patients because he lacks the time necessary to treat them. He would be in deep financial trouble if he gave adequate time to the patient necessary to treat him properly.

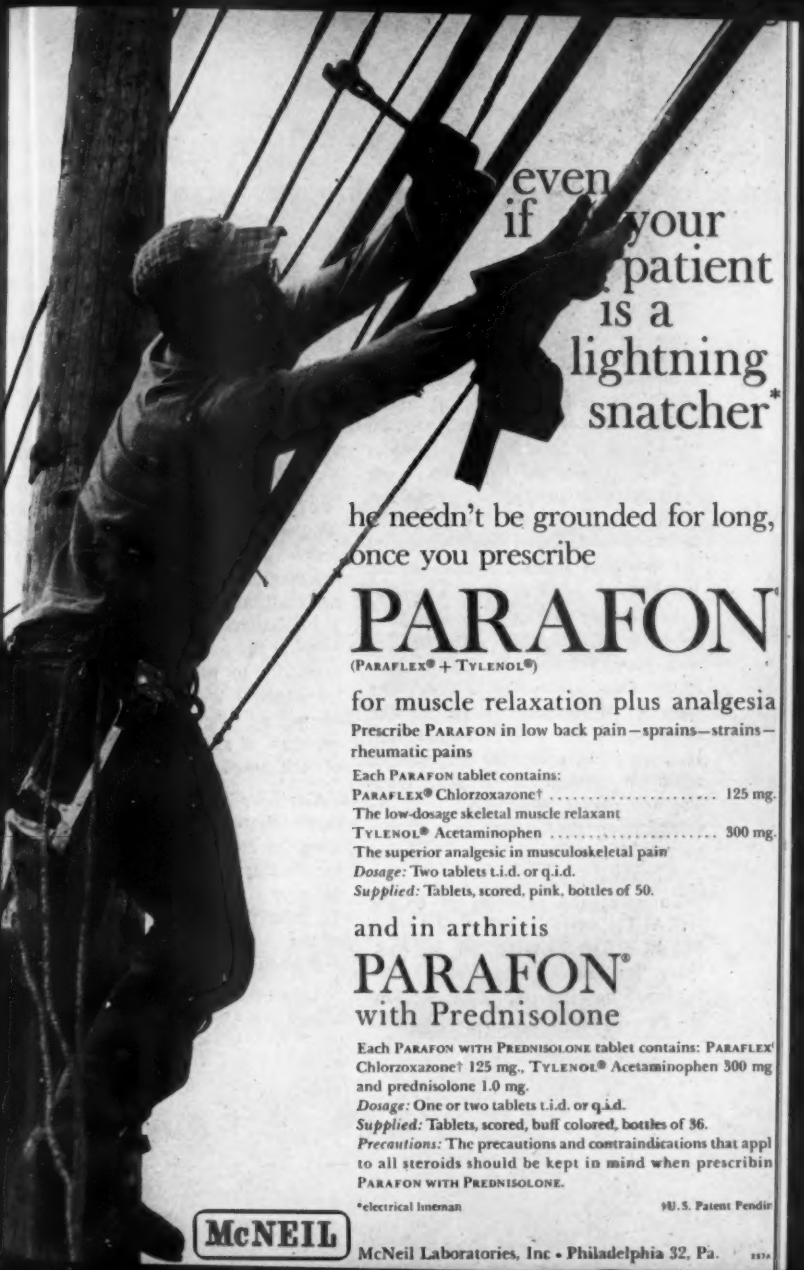
The patient does not realiz that it is not the best medical car he is getting, only the cheapes

Diagnosis is often delayed a proper studies are either re stricted or not done. Any dis pute between patient and the doc tor will be handled by "Kranken kasse" in favor of the patient.

Patient, doctor lose

The tremendous amount of red tape involved with a socialized system like this one not only ties down the physician, keeps him away from his patients, but also increases the cost, resulting in constant raises in the dues, and, decreases in the benefits to physicians. It is obvious that the "Krankenkasse" cannot lose. It is the doctor who suffers primarily and through him also the patient who does not receive good medical care.

Changes in the system cannot be expected as the majority of the patients are voters who think they are getting a good deal, not realizing how *cheap* a deal it really is.


even if your patient is a lightning snatcher*
he needn't be grounded for long, once you prescribe
PARAFON
(PARAFLEX® + TYLENOL®)
for muscle relaxation plus analgesia
Prescribe PARAFON in low back pain—sprains—strains—rheumatic pains
Each PARAFON tablet contains:
PARAFLEX® Chlorzoxazone† ..... 125 mg.
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The superior analgesic in musculoskeletal pain
Dosage: Two tablets t.i.d. or q.i.d.
Supplied: Tablets, scored, pink, bottles of 50.
and in arthritis
PARAFON®
with Prednisolone
Each PARAFON WITH PREDNISOLONE tablet contains: PARAFLEX® Chlorzoxazone† 125 mg., TYLENOL® Acetaminophen 300 mg and prednisolone 1.0 mg.
Dosage: One or two tablets t.i.d. or q.i.d.
Supplied: Tablets, scored, buff colored, bottles of 36.
Precautions: The precautions and contraindications that appl to all steroids should be kept in mind when prescribin PARAFON WITH PREDNISOLONE.
*electrical lineman
†U.S. Patent Pendir
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McNeil Laboratories, Inc. • Philadelphia 32, Pa.

A Message about Project HOPE

by Dr. William B. Walsh

President, The People-to-People Health Foundation

HOPE is a floating medical center which will bring America's medical knowledge to less fortunate peoples overseas. Under the People-to-People Program inaugurated by President Eisenhower, Americans are preparing to make a dramatic contribution to the health of friendly nations in the Far East.

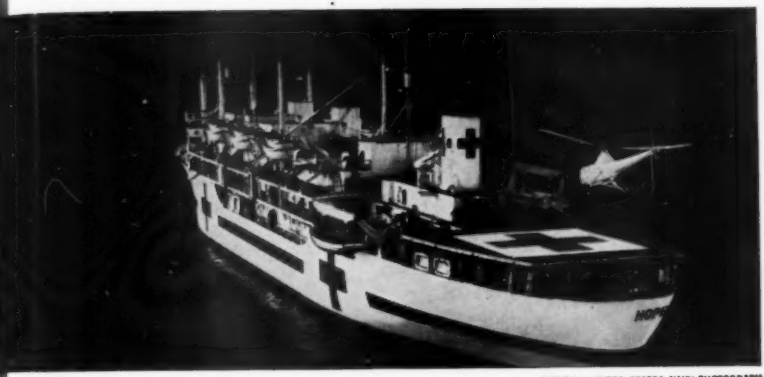
The People-to-People movement is an effort to strengthen understanding with peoples abroad through citizen, rather than government action. The sponsor of Project HOPE is the People-to-People Health Foundation, Inc., a private, non-profit corporation, aided by a committee from the medical and dental professions; it is the organization of the People-to-People movement in the field of medicine and health.

To assist the program of HOPE (HEALTH OPPORTUNITY FOR PEOPLE EVERYWHERE), the U.S. Navy has made available a fully equipped hospital ship. Chartered by the Foundation, and re-named HOPE, the ship will be manned and operated by the Foundation, *solely with the support of the American people.*

In 1960 HOPE—the floating medical center—will leave America for Southeast Asia. Medical activities will follow a program pre-arranged with the doctors of the countries where the ship will make its stops (generally for a minimum of four months). The hospital beds of the ship will be used primarily to provide an opportunity for medical teaching, rather than in attempting to meet the overwhelming problem of caring for the vast mass of sick people in Asiatic lands.

Carefully worked out budget estimates show that the cost of organizing the HOPE Project and enabling the floating medical center to operate for a year will amount to $3,500,000. To raise this sum, HOPE is turning to the American people—individuals, organizations, business firms.

May we depend on you to help us launch HOPE?



OFFICIAL UNITED STATES NAVY PHOTOGRAPH

YOUR HELP CAN COME BACK A HUNDRED TIMES OVER

If enough of us help, the S.S. Hope will be outbound in 1960. First port of call: Indonesia. A bold health project called Hope will be underway.

The need for Hope—and your help—is crucial. In many nations, too many health hazards exist. Too many people robbed of the will to live and work. Too few hands to help. Often, there may be one doctor for 100,000.

Hope's approach is most practical. Help where a nation's doctors ask help. Then help them help *themselves* to health. By training, upgrade their skills — multiply their hands. Hope's doctors, dentists, nurses and technicians will man a center complete to 300-bed mobile unit, portable TV.

With Hope, you can not only make every dollar do the work of many, you can earn a priceless dividend. With health comes self-respect. Men or nations who are at peace with themselves are less likely to war with their world.

Hope is *yours* to give. It's a people-to-people project. For one year's worth, 3½ million Americans must give a dollar. Please make it more if you can.

GIVE TO
HELP LAUNCH HOPE

Don't wait to be asked.
Mail your contribution now to HOPE, Box 9808, Washington 15, D. C.

In addition to your technical know-how . . .

. . . What Does Your Patient Expect From You?

Herbert J. Levine, M.D.

Honest answers, brief explanations, courtesy at all times, availability in an emergency—here are some of the qualities the patient has a right to expect in his physician. The author tells you why you should consider these—and others.

Patients expect many qualities from their doctor. Perhaps the most important, other than professional competence, is honesty. Patients do expect honesty from a physician at all times. They expect you to be truthful as to whether you can or cannot help them. Honesty from the physician gives the patient confidence.

The average patient does not expect the doctor to say, "I can cure you." He does want to know if *you feel he can be helped.*

Most patients realize that the Lord did not make any one physician so smart that he is able to help everyone.

Patients want intelligible answers to their questions, not in tongue-twisting or technical terms, but in simple words and as briefly as possible. They become fearful when explanations are dramatized.

They do not expect a busy practitioner to talk to them for hours about their ailments. They do appreciate brief explanations with the aid of medical charts. Just a few words and pictures or roughly drawn diagrams to aid them in understanding their illness. Just a few extra minutes of the doctor's time; again, time well spent because it enables the patient to build confidence in his doctor.

Other physicians

Patients admire the physician who acknowledges his limitations and respect him when he seeks consultation. They develop a feeling of well being and satisfaction when their physician refers them to another doctor—even to distant medical centers—for further evaluation and therapy. They appreciate the

physician who permits them to read the original reports received from the consultant (within certain limitations) as well as an interpretation of medical terminology contained in the reports. They are pleased when offered a copy for their personal files.

Patients distrust the doctor who criticizes and ridicules his colleagues behind their backs in public places or while sitting in the sanctity of their private office, but who are all "honey and sugar" when talking to these same colleagues face to face.

Courtesy

Patients expect to be treated with courtesy at all times. Being nice to people involves no expenditure of money. They dislike rough and sarcastic language. They know that a physician is supposed to be an individual of education, culture and refinement. They find it offensive when he uses foul and abusive language in their presence.

They become upset at office personnel who are abrupt and discourteous to indigents and the reverse to the more prosperous. They become offended when a member of the physician's family talks to them rudely over the phone, or who hangs up abruptly with an irritated "He's not here!" instead of a polite and courteous reply.

Patients want their doctor to be less formal, to joke and laugh with them, to be kind and sympathetic, not stiff, formal and unsmiling.

Visits

Patients have a feeling of satisfaction when their doctor visits them at least twice daily while they are confined in the hospital. They feel that they have placed their life in his hands, and if they see him, even if only for a brief moment, they sense that they are not being forgotten. They become angered and anxious if their physician does not see them for four or five days, except perhaps in a large hospital staffed with interns and residents who see the patient daily.

Personal

People respect the physician who requests permission for an autopsy on a deceased member of the family. They admire the integrity of the doctor who informs them of the final autopsy diagnosis even though it differs from the original clinical diagnosis.

Patients build up a personal dislike for the physician who sends his office nurse to make

house calls. They know that she is not a licensed physician. It leaves them disturbed and affronted when a nurse walks into their home carrying a doctor's bag, even though it be to give a "shot" at the doctor's instructions.

Office procedure

Patients expect their physician to give them the results of expensive x-ray and laboratory tests for which they have spent hard earned dollars. They dislike verbal reports from office personnel. They are better satisfied when permitted to read the original reports, with the results explained to them.

Patients lose faith in a physician when he uses inappropriate phrases such as "Let's try this medicine. I don't know what it will do; if it doesn't work, we will try something else."

Patients dislike being rushed

"We've been pretty patient with you Mrs. Manning."

through the office as though they were on an assembly line, especially after a long wait in the reception room. They feel that they are entitled to a few minutes of the doctor's time.

House calls

Patients who are acutely ill expect house calls to be made, be it by day or by night, rain or shine. They distrust and fear telephone diagnosis and therapy. They expect the doctor to remember the long tiresome hours spent in his reception room awaiting their turn to be seen.

The average patient will not request a house call unless he feels it is really urgent. As a rule they sympathize with the busy practitioner and are very apologetic when they do ask for a house call. But their wrath is evoked if their doctor is unavailable and another is not ready to respond in his place.

They do realize that there are times when a physician cannot be in two places at the same time and are grateful and appreciative when the office personnel, answering service or a member of the physician's family contacts a colleague for help.

Patients expect their physician to be available for help in an emergency. When he is out of town, they expect him to make adequate arrangements with one of his colleagues to take over during his absence.

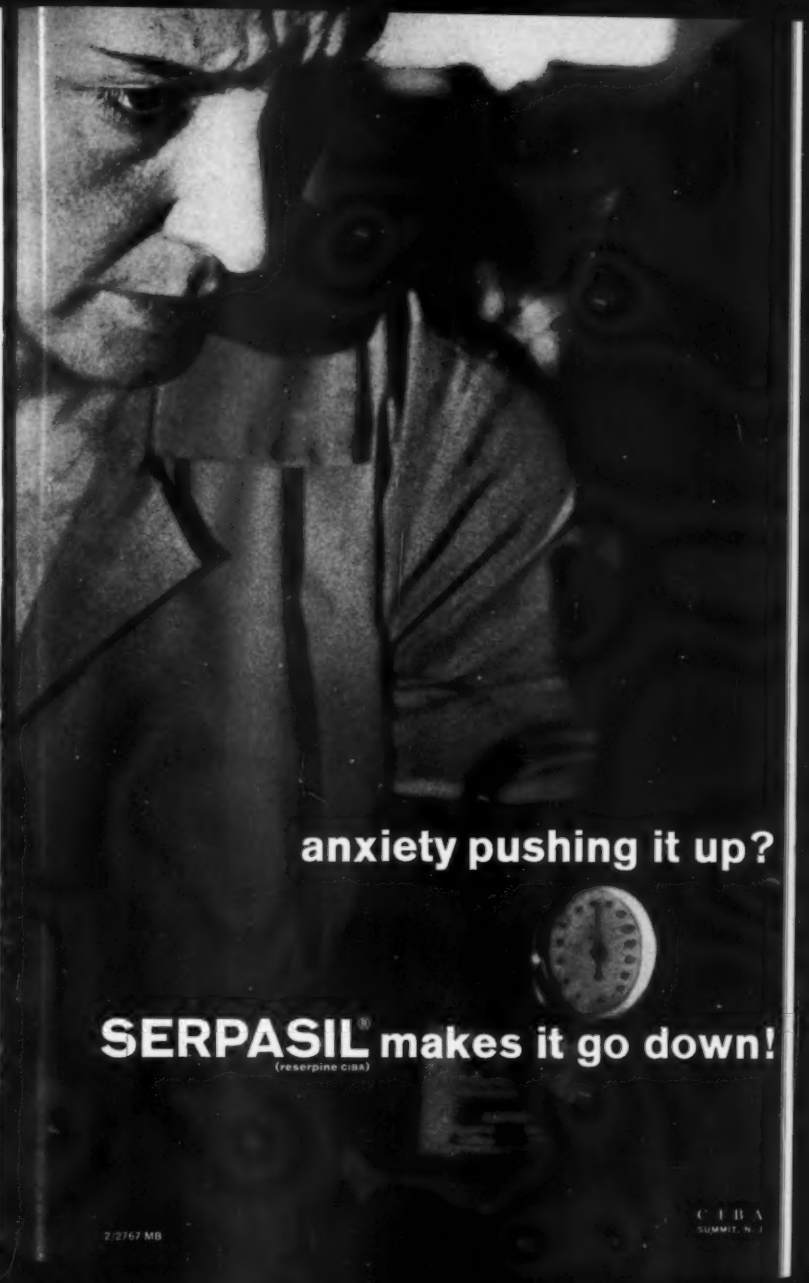
Contribution

In recent years, Medicine has lost some of its prestige among the laity. Some of the foregoing points have been ignored and have more than contributed their share in creating poor public relations for one of the few remaining, unselfish professions serving mankind.

By avoiding what the average patient does not expect from his physician and understanding what he does expect, a great contribution can be made toward better public relations between physicians and patients.

The famous Doctor Osler once said: "the practice of medicine should be looked upon as a calling, a sort of religion. . . a profession and never just a business. . . . It should be an affair of the heart as well as of the head."

His words should be imprinted forever into the mind and heart of the true physician.


anxiety pushing it up?
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SUMMIT, N. J.

Govt. Medical Care For Aged

Two Bills Under Consideration—The Forand bill and an Administration-supported plan for Federal moneys to assist the aged in paying for medical care costs are competing for support. Indications are that the former, which covers only social security beneficiaries—and calls for social security tax increases—is certain to draw the President's veto if it reaches him in its present form. The Administration plan, depending about half on Government general funds, half on state funds—plus a $24 annual cost for all those over age 65 who elect to come under the plan—is not expected to get through the legislature without major changes. Except for those already drawing public welfare money (who would get full medical costs paid for them), the latter plan would help those who pay no federal income tax or whose income is not more than $2500 a year. Plan would pay for: 80% of medical care costs after the first $250, up to 180 days hospital care, all fees of M.D.s and dentists, care in a nursing home for unlimited period, private nurses, up to $350 of Rx costs and $200 of lab and x-ray services, and home care if arranged by a hospital.

M4

Gifts and Prizes for Doctors..

Handcarved wooden miniatures by old world craftsmen

Imported from Europe, these richly detailed, hand-painted figures make ideal conversation pieces, gifts, bridge prizes, etc., and they add a bright note to any home or office.

Each 7 inches high—$7.95 postpaid, or $7.45 each by the dozen.

Replicas of 13 different figures for your choice—Gynecologist (M1), Pediatrician (M2), Psychiatrist (M3), General Practitioner (M4), Surgeon (M5), Orthopedist (M6), Ophthalmologist (M7), Ear, Nose and Throat Specialist (M8), Dentist (M9), Radiologist (M10), Pharmacist (M11), Veterinarian (M12), Chemist (M13).

Money refunded if not satisfactory. Please order by number.

M5 M10 M11

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Provera (medroxyprogesterone acetate) 2.5 mg.
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DOSAGE: 1 tablet 1 or 2 times daily, 5-10 days before the period.

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CYTRAN

GETS AT THE CAUS

to restore hormonal balance.

corrective therapy Because Cytran contains new progestin, Provera,† you can now reach the c of premenstrual tension—hormonal imbalance. Estr progesterone ratio is adjusted to more normal pre strual balance. Thus even abdominal discomfort, s ness, fatigue—symptoms incompletely controlle mere symptomatic treatments—are effectively reli

to comfort the patient...

symptomatic therapy An effective diur (Cardrase†) and a mild tranquilizer (Levanil†) a symptomatic relief while Provera works to effect a toration of hormonal balance. They also supplement activity of Provera in those rare cases where restor of hormone balance does not completely eliminate e and anxiety/tension.

*TRADEMARK †TRADEMARK, REG. U.S.

FP

Upjohn

F PREMENSTRUAL TENSION

MEDIQUIZ CONTEST

GRAND PRIZE TOUR: LONDON

If you're the big winner of our upcoming Mediquiz Contest, London, England will be your first stop. Here's a brief glimpse of some of the sights in Britain's capital.

Whatever the RESIDENT PHYSICIAN Mediquiz Grand Prize winner's special interest—surgery, pathology, medicine, pediatrics, etc.—it's more than likely that London will rank high on his list of European medical centers.

London will be the first stop on the two-week European tour for two.* After the BOAC Intercontinental 707 jet has whisked you, the winner, to the British capital, you will meet some of the foremost English specialists in your field.

Training centers, clinics, research labs will all be part of your medical itinerary.

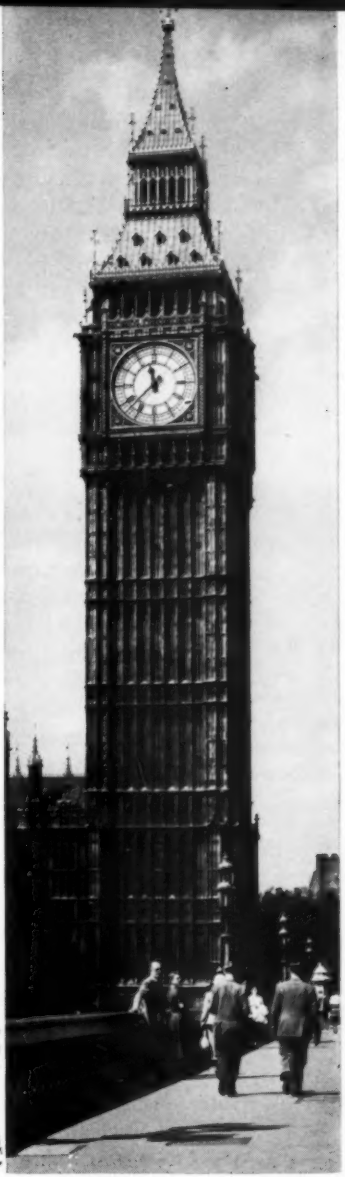
But all of your time will not be consumed by professional activities. You certainly will have time to see London.

Though it is a sprawling city (700 square miles), its major points of interest are clustered in compact areas. Many visitors concentrate their activities in the West End, site of posh hotels such as the Savoy and Claridge's, the fine shops

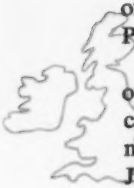
* All expenses for two persons (hopefully for a house staff member and his hard-working wife), in deluxe accommodations, will be paid by RESIDENT PHYSICIAN.

A Beefeater stands guard at the Tower of London where he and his colleagues also act as guides. Right: One of London's most famous landmarks—Big Ben.

British Travel Association



of Regent and Old Bond Streets, and Hyde and St. James's Parks.



Piccadilly Circus, with its famous statue of Eros, is another West End landmark. Within walking distance of Piccadilly are Big Ben and the Houses of Parliament, Westminster Abbey, 10 Downing Street, Scotland Yard, St. James's Palace and Trafalgar Square.

The City

Traveling east, the visitor finds another concentration of tourist sights. Double decker bus or the underground (subway) make it easy to get to the City (always capitalized), the most important square mile in London.

Here is the financial and mercantile center which was a walled city in Roman times. Though only the wall's foundation remains, the City is still a self-governing enclave which the Queen herself enters only at the invitation of the Lord Mayor and City Corporation or the Bishop of London, usually for a special function at the Guildhall.

No matter how little time the visitor has for the City, there are certain institutions he will want to see. Topping the list is the Tower of London, oldest fortress in Britain and grim repository of 900 years of history.

The great dome of St. Paul's Cathedral overshadows the City from Ludgate Hill. Here are the tombs of Nelson and Wellington and the grave of Sir Christopher Wren, 17th century creator of St. Paul's and 51 other London churches. (Wren's famous epitaph: "Reader, if you seek his monument, look around you.")

Other attractions include the "Old Lady of Threadneedle Street," that symbol of stability, the Bank of England; the impressive quarters of Lloyd's, where the Lutine Bell still tolls the news of maritime disasters, and the splendid halls of those medieval "closed shops," the City's craft guilds.

A casual stroll through the City yields a variety of pleasures. In the financial center you'll mingle with silk-toppered Bank of England messengers, sombre-suited city clerks and the City's own police force, and at Temple Bar you come

St. Paul's (top, left) is the site of the tombs of Nelson, Wellington and Christopher Wren, the cathedral's creator. Above: Trafalgar Square. Sightseeing of another kind is provided by street entertainers in the Soho district.

BTA Photos

when the rheumatic disorder is more than salicylates alone can control...
...and the condition requires less than steroids alone

A

A Divi

upon the bucolic calm of the quadrangles and gardens of the Temple, citadel of the legal profession.

Food and fun

If you're in the area at lunchtime, you can stop off at Ye Old Cheshire Cheese, Dr. Samuel Johnson's favorite haunt, for steak and kidney pudding and strong beer. Incidentally, London's pubs, whether the neighborhood variety or a famed tavern, are wonderful places to rub shoulders with the locals and have a meal. Many pubs serve good lunches for as little as six shillings (84 cents).

But back to the West End. . . . A short walk north from Trafalgar Square will take you into Soho, which is bounded on its four sides by Oxford and Regent Streets, the great shopping thoroughfares; Shaftesbury Avenue, center of London's theater world, and Charing Cross Road, home of Jacks-of-all-trades and hub of the "pop" music industry.

Within the boundaries of Soho—the name comes from a seventeenth century hunting cry—you will find hundreds of excellent small restaurants specializing in almost every kind of food known to man. All about are more than 50 "live" theaters presenting everything from Shakespeare to striptease. Europe's only permanent Yiddish repertory theater is here. In the streets you'll see the oddly garbed "buskers" who make a living entertaining crowds with songs and acrobatic stunts.

Tea and whelk

If you'd like to see an old-fashioned British music hall, you can go to Collins' Music Hall on Essex Road in Islington Green. Tea and whelk stalls (a whelk is a shellfish) are a fixture here, and patrons with their hats on eat fish and chips and show their appreciation for the acts by joining in.

London is a city of great variety and great charm. Dr. Johnson put it this way:

"When a man is tired of London, he is tired of life; for there is in London all that life can afford."

(See pages 77-79 for further contest details)

Pageantry is as much a part of the London scene as the umbrella. Here the Household Cavalry appears on the Mall. Another, and very different, face of the city is seen at the many lively, noisy outdoor markets.

Right: Pan Am Airways Photo

A Guide to the Low-Priced Foreign Cars

You've seen the U. S. compact cars. They're smaller than their overgrown brothers, more economical to operate and cost less to buy. Now, if you're looking for still more economy, you will turn to the smaller and lighter-weight imported cars that have the below-$2000 market virtually to themselves.

Reprinted from the February 1960 issue of "Changing Times," The Kiplinger Magazine.

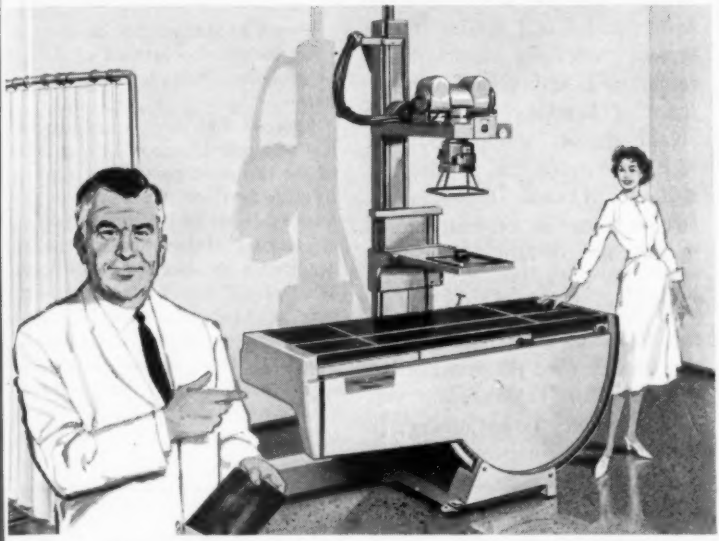
A considerable number of people in this country have already been sold on the unique features of the small foreign cars. In 1955 the imported car share of the U. S. auto market was less than 1 percent. Last year more than 600,000 imported cars were sold in the U. S., about 10 percent of total car sales. Over half of the foreign cars sold were in the $1,500 to $2,000 price range.

Now, apparently, all the talk about the compactness and economy of the new U. S. cars is causing even more people to look closely at the imports. *Automotive News* reports: "The new compact cars have been welcomed just about as warmly by imported-car dealers as by the public," and suggests that if sales of imported cars have been hurt by the new compacts, "everybody should hurt so good."

Why did more than 85 percent of foreign-car owners in a survey last year say that their next car would be another imported model? Here are their principal reasons, in order of importance.

● *Economy of Operation.* You don't begin to appreciate the potential saving in owning a small imported car until you figure the total annual costs, as in the example in the box on the next page.

The choice of confidence...



diagnostic x-ray equipment planned for private practice!

Few who purchase x-ray equipment have time to thoroughly test the quality of materials, workmanship and technical performance offered by all the makes of x-ray units. And happily this is not necessary.

The manufacturer's *reputation* is worth more than anything else to you in choosing x-ray equipment, one of the most complex professional investments you will ever face.

General Electric has created "just what the doctor ordered" in the 200-ma Patrician, in terms of both reasonable cost and operating qualities. Here diagnostic x-ray is ideally tailored to *private practice*. Patrician provides everything you need for radiography and fluoroscopy — and with consistent end results, since precise radiographic calibration is as much a part of the Patrician combination as it is of our most elaborate installations. Ask your G-E x-ray representative about the Patrician "package," or return our coupon below for illustrated literature.

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.....

● *Ease of Handling and Parking.* A small foreign car that is a ton lighter and 4 feet shorter than a typical American model offers remarkable agility and convenience of handling for short-run neighborhood shopping trips, rush-hour traffic and parking.

● *Low Annual Depreciation.* Except with an off-beat model that declines in value abnormally fast, your dollar depreciation on a $2,000 car will invariably be less than that on a more expensive model. (See the box again.)

● *Quality of Workmanship.* Although quality is not uniformly high among the imports, many of the foreign cars show evidence of attention to details of construction, trim and furnishing that is impressive in any price range.

● *Low Original Price.* If you pay cash, your original investment in many of the small foreign cars can be as little as half the amount of money you would tie up in a $3,000 U. S. sedan. If you finance it, down payment, instalments and charges are lower.

In addition to all this, many of the foreign cars in the $1,000 to $2,000 price range offer structural and mechanical features that aren't duplicated in many U. S. cars costing twice as much. For example: unit frame and body construction; independent suspension on all four wheels; fully synchromesh transmissions (no clashing of gears in manual shifting, even from second to first gear); front-wheel drive and efficient aluminum engines.

One word of caution, however. Service on foreign makes has improved generally over the past few years, but it's still haphazard for some makes with limited dealer facilities. To be safe, check with foreign-car owners in your area as to their experience.

The results of the most recent Mobil Mileage Rally for small cars will give you an idea of the

HOW MUCH ECONOMY?

Here's an illustration of the total effect on your pocketbook of cheaper depreciation, operation and maintenance.

Suppose that three years ago you had had your choice of buying either of the two most popular foreign cars (Volkswagen or Renault), or the least expensive of the Big Three's six-cylinder, four-door sedan models, equipped with standard transmission. What would your total costs have been as of today for each?

Depreciation figures are based on actual NADA "Official Used Car Guide" prices, but the depreciation of the Renault is more typical of foreign cars than that of the Volkswagen,

ANNUAL COST	U.S. CAR	VOLKSWAGEN	RENAULT-DAUPHINE
Average depreciation	$453	$190	$328
Insurance	146	122	122
License fees	12	8	8
Gas, oil, maintenance, repairs and tires	377	213	207
Total	$988	$533	$665

which is still in short supply in this country.

Other fixed and operating expenses are based on costs for a typical Midwestern area. They were compiled by Runzheimer and Co., of Chicago, Ill., automobile operating-cost analysts for major fleet and leasing operations.

The Volkswagen's annual cost per mile, on a 10,000-mile/year basis, is a little more than half that of the U.S. six-cylinder model; the Renault's, two thirds.

If you had driven the Volkswagen for the past three years, your total saving over the costs of the "low-priced" U.S. model would have been $1,365; with the Renault, $969.

potential and relative gas mileage of many of the imported cars. The rally was run over a course of 345.6 miles at an average speed of 38.89 mph.

But don't expect to match these records, or even all the claims of manufacturers, under normal driving conditions. More realistic guides to gas mileage are the actual performance figures used in calculating the operating costs in the box above for the Volkswagen (32 mpg) and the Renault Dauphine (34 mpg).

Even though you don't break any records, you can still save as much as $100 a year on gasoline by driving one of the small foreign cars instead of a typical six- or eight-cylinder American model.

Here are the figures posted by professional drivers in the Mobil run. Remember again, take them with a grain of salt.

Fiat 500—55.3 mpg
NSU Prinz—48.67
Renault Dauphine—46.25
Volkswagen—43.67
Renault 4CV—42.72
Austin A-40—42.24
Morris 1000—41.34
Austin A-55—39.21

Foreign Cars Price

make & series	price port of entry	no. of cylinders	horse-power	shipping weight	wheel base
GOGGOMOBIL T-400	$ 995	2	22	915 lbs.	70.8"
BMW ISETTA 300	1,048	1	13	757	58.0
VESPA 400	1,080	2	20	800	66.7
FIAT 500	1,098	2	21	1,069	72.4
RENAULT 4CV	1,345	4	28	1,322	82.8
GOGGOMOBIL T-700	1,395	2	34	1,411	78.7
LLOYD 600	1,395	2	29.5	1,240	78.8
BMW 600	1,398	2	26	1,135	66.9
FIAT 600	1,398	4	28.5	1,290	78.8
NSU PRINZ	1,398	2	26	1,080	78.8
MORRIS 1000 STANDARD	1,495	4	37	1,736	86.0
VOLKSWAGEN	1,565	4	36	1,609	94.5
SKODA S-440	1,575	4	53	1,984	94.5
FORD ANGLIA	1,583	4	41	1,580	90.5
DATSUN	1,616	4	37	2,035	87.4
RENAULT DAUPHINE	1,645	4	32	1,397	89.0
FORD PREFECT	1,661	4	61	1,683	87.0
METROPOLITAN	1,673	4	55	1,890	85.0
WARTBURG STANDARD	1,688	3	38	2,120	96.5
PANHARD GRAND LUX	1,697	5	50	1,764	101.0
SIMCA ARONDE DELUXE	1,698	4	50	1,925	96.3
TRIUMPH	1,699	4	40	1,680	84.0
HILLMAN MINX SPECIAL	1,735	4	56.5	2,122	96.0
FIAT 1100	1,743	4	48	1,940	92.1
AUSTIN A-40	1,795	4	37	1,596	83.5
SAAB 93-F	1,895	3	38	1,775	98.0
GOLIATH 1100	1,949	4	46	1,896	89.4
VAUXHALL VICTOR	1,957	4	55	2,125	98.0
OPEL REKORD	1,958	4	57	1,922	100.0
DKW	1,995	3	50	2,005	92.0
FIAT 1200	1,998	4	63	2,050	92.0

Specifications are for the least-expensive models in the line. Prices are at East Coast port of entry, and do not include transportation charges (which average $50 to the Midwest, $100 to the West

Below $2,000 . . .

over-all length	over-all width	no. of doors	seat width front	seat width rear	headroom front	headroom rear	no. of U.S. dealers
114.2″	50.4″	2	47.0″	—	34.5″	—	175
89.9	54.3	1	43.5	—	36.0	—	476
112.2	50.0	2	48.0	—	38.0	—	189
117.0	52.0	2	45.5	—	34.6	—	426
142.3	56.3	4	46.0	40.0″	37.5	33.0″	800
135.3	58.0	2	49.0	51.2	38.6	37.8	175
132.1	55.8	2	44.0	46.0	35.5	34.0	423
114.5	55.1	2	40.5	46.5	37.0	35.5	476
130.5	54.3	2	44.5	43.5	36.2	33.0	426
122.8	56.0	2	37.0	48.0	36.0	33.0	281
148.0	61.0	2	36.0	41.0	36.0	35.0	670
160.6	60.6	2	46.0	51.6	38.6	32.7	410
160.0	63.0	2	46.0	45.6	37.6	36.2	125
153.5	57.3	2	50.5	43.0	38.1	37.0	668
152.7	57.7	4	43.0	47.0	37.3	35.0	287
155.0	60.0	4	51.0	50.0	37.5	35.5	800
149.8	60.8	4	50.5	48.5	38.3	36.8	668
149.5	61.5	2	49.8	—	35.8	—	1,671
167.0	62.0	4	51.0	51.5	37.5	37.0	412
180.0	63.0	4	58.0	56.0	35.0	33.0	44
162.2	62.6	4	50.8	49.8	34.2	34.0	724
145.0	58.0	4	42.0	39.0	38.0	35.0	700
162.0	60.8	4	47.0	52.5	38.5	36.8	804
154.3	57.4	4	46.1	49.0	36.0	34.0	426
72.5	59.4	2	39.0	37.0	36.5	34.5	670
158.0	62.0	2	38.0	44.5	38.0	35.0	133
158.2	64.2	2	53.0	43.0	36.5	34.5	371
167.8	62.5	4	51.6	52.0	35.5	35.3	2,734
174.5	63.6	2	52.8	53.1	36.0	34.8	3,215
166.0	66.0	2	51.6	54.0	37.6	35.2	150
154.3	57.4	4	47.5	49.0	34.5	33.5	426

Coast); dealer handling and preparation charges in most cases (about $50); state and local taxes; optional equipment (although heaters are included as standard equipment in most imports).

Triumph—38.61 mpg
Citroën 2CV—38.51
Fiat 1100—38.43
Datsun—37.37
Simca Aronde—37.25
Fiat 1200—36.99
DKW—36.69
Opel—36.42

There are some excellent transportation values among the imports. Your choice—taste and prejudice aside—will depend on the values you attach to economy of operation, balanced against your particular comfort, passenger-capacity and transportation needs. There are three categories in terms of size and passenger capacity in the $1,000 to $2,000 price range.

- *$1,000 to $1,400.* This is

THE FOREIGN STATION WAGONS

make & series	price port of entry	no. of cylinders	horse-power	shipping weight	wheel base
LLOYD 600	$1,545	2	29.5	1,240 lb	8.8"
GOGGOMOBIL ROUSTABOUT	1,595	2	33	1,488	8.0
HILLMAN HUSKY	1,639	4	51	2,020	6.0
FORD ESCORT	1,689	4	36	1,773	7.0
FIAT 600 MULTIPLA	1,658	4	24.5	1,603	8.8
MORRIS 1000 STANDARD	1,798	4	37	1,764	6.0
DATSUN	1,818	4	48	2,268	7.4
WARTBURG STANDARD	1,898	3	38	2,290	6.5
TRIUMPH	1,899	4	40	1,780	4.0
SIMCA ARONDE (CHATELAINE)	1,963	4	50	2,041	6.3
FIAT 1100	1,998	4	48	1,985	2.1
GOLIATH 1100	2,095	4	46	2,068	8.3
TEMPO VIKING RAPID	2,171	4	32	4,053	6.3
TAUNUS COMBI-WAGON STANDARD	2,237	4	67	2,291	2.5
VOLKSWAGEN	2,245	4	36	2,447	4.5
VAUXHALL VICTOR	2,262	4	55	2,255	8.0
OPEL CARAVAN	2,293	4	57	2,077	0.0
HILLMAN MINX	2,299	4	56.5	2,265	6.0

the minimum transportation class. The one- to four-cylinder engines are efficient and economical, but don't expect too much in the way of performance and comfort. Most models are adequate only for two passengers, although you may be able to squeeze one or two small children into the rear seating space. These cars will do for in-town commuting and shopping trips—not for highway travel.

● *$1,400 to $1,700.* The four-passenger Renault Dauphine, Volkswagen and English Ford (the most popular cars of this group) offer the basic size, power and performance for almost any type of moderate driving.

● *$1,700 to $2,000.* In this

Here are the foreign-built station wagons currently selling for less than $2,300, the average list price of the least-expensive U.S.-built wagons. For an explanation of the price column, see the auto chart.

shipping weight	wheel base	over-all length	over-all width	no. of doors	no. of seats	cargo length tailgate closed	cargo length tailgate open	unobstructed rear opening height	unobstructed rear opening max. width	unobstructed rear opening min. width
,240 lb	8.8"	132.1"	55.8"	2	2	52.0"	52.0"	29.0"	44.0"	28.0"
,488	8.0	142.0	58.0	3	2	54.0	54.0	38.0	52.0	52.0
,020	6.0	152.0	60.5	2	2	50.3	50.3	35.0	52.0	37.5
,773	7.0	140.4	60.8	2	2	67.0	67.0	27.1	43.3	35.8
603	8.8	140.8	57.0	4	2	50.0	50.0	—	—	—
764	6.0	148.0	61.0	2	2	50.0	50.0	29.0	41.0	39.0
268	7.4	159.8	57.7	2	2	65.0	88.0	35.0	38.0	36.5
290	6.5	169.0	62.0	2	2	64.0	64.0	33.5	37.0	35.0
780	4.0	144.0	58.0	4	2	57.0	57.0	29.0	37.0	37.0
041	6.3	158.1	62.8	2	2	65.0	88.2	36.5	52.0	38.5
985.	2.1	149.1	57.4	4	2	55.5	55.5	31.0	32.1	32.1
068	8.3	158.3	64.2	2	2	66.0	66.0	30.0	35.0	33.0
053	6.3	172.0	67.5	3	2	96.3	96.3	44.0	42.8	42.8
291	2.5	172.2	65.8	2	2	63.0	79.1	25.6	39.8	37.5
447	4.5	168.5	68.9	2	3	32.7	32.7	28.7	35.4	35.4
255	8.0	167.8	62.5	4	2	63.8	63.8	26.6	48.1	36.7
077	0.0	174.5	63.6	2	2	68.9	68.9	30.3	32.1	32.1
265	6.0	162.0	60.8	4	2	59.5	59.5	33.0	48.0	48.0

group are the cars, such as the Austin, Hillman, Opel and Vauxhall (as well as some of the more expensive models in the $1,400 to $1,700 category), that are most comparable for the U. S. compacts in capacity, comfort and performance.

As for station wagons, most of the imports listed do not have the interior capacity, comfort and sedanlike qualities of the American species. But many of the van-type foreign wagons (Taunus and Volkswagen, for example) offer utility and versatility of interior space—for hauling children, furniture, camping equipment—that are unequaled in any U. S. car.

The charts on the cars and the station wagons answer the questions: "How compact can you get?" and "At what price?"

The 24 makes included in the auto chart offer about 90 different models. (U. S. manufacturers make only six models selling for less than $2,000.) Included are the best-selling imports of 1959: Volkswagen, Renault, English Ford, Opel, Fiat, Hillman, Triumph and Vauxhall — in that order. Not included are the "sports" models (Berkeley and Austin-Healey Sprite, for example) that sell for less than $2,000, and the numerous imports that sell for $2,000 and up (up to $24,650 for the most expensive Rolls-Royce). If you are interested in the foreign cars that are most comparable in price to the U. S. compacts, take a look at the Ford Consul, Zephyr or Zodiac, Borgward; Peugeot; Singer Gazelle or Volvo.

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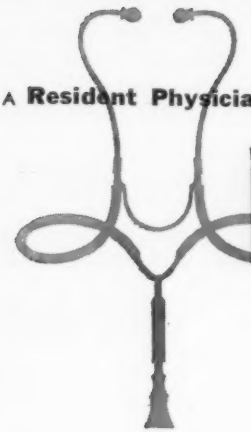
My chief is Dr. (full name) .....

I expect to complete my training here: ..... month ..... year

Former Hospital Address:

Hospital Name ..... City ..... State .....

A **Resident Physician** MONTHLY FEATURE



Mediquiz®

These questions were prepared especially for RESIDENT PHYSICIAN *by the Professional Examination Service, a division of the American Public Health Association. Answers will be found on page 162.*

1. The most plentiful plasma proteins are:

A) Cryoglobulins.
B) Fibrinogen and thromboplastin.
C) Alpha-2 globulins.
D) Albumins.
E) Alpha-1 globulins.

2. A false positive Benedict test may follow the administration of:

A) Steroids.
B) Oral glucose.
C) Aspirin.
D) Pentobarbital.
E) Erythromycin.

3. Heberden's nodes resemble the changes seen in:

A) Acromegaly.
B) Scleroderma.
C) Hemolytic anemia.
D) Sarcoid.
E) Raynaud's phenomenon.

4. A positive sensitized sheep cell agglutination reaction occurs in:

A) Pulmonary osteoarthropathy.
B) Peripheral rheumatoid arthritis.
C) Gout.
D) Rheumatic fever.
E) Psoriatic arthritis.

5. Capacity of the liver to synthesize protein may be judged by:

A) Serum transaminase levels.
B) Graham-Cole test.
C) BSP excretion.

Naturetin—reliable therapy in edema and hypertension—maintains a favorable urinary sodium-potassium excretion ratio . . . retains a balanced electrolytic pattern:

"...the increase in urinary output occurs promptly..."[1]
"...the least likely to invoke a negative potassium balance..."[2]
"...a dose of 5 mg. of Naturetin produces a maximal sodium loss."[2]
"...an effective diuretic agent as manifested by the loss in weight..."[3]
"...no apparent influence of clinical importance on the serum electrolytes or white blood count."[3]
"...no untoward reactions were attributed to the drug."[4]

Although Naturetin causes the least serum potassium depletion as compared with other diuretics, the supplementary potassium chloride in Naturetin c̄ K provides added protection when treating hypokalemia-prone patients, patients with conditions where the likelihood of electrolyte imbalance is increased or during extended periods of therapy.

Numerous clinical studies confirm the effectiveness[1-15] of Naturetin as a diuretic and antihypertensive—usually in dosages of 5 mg. per day.

■ the most potent diuretic, mg. for mg.—more than 100 times as potent as chlorothiazide ■ prolonged action—in excess of 18 hours ■ convenient once-a-day dosage—more economical for patients ■ low toxicity—few side effects—low sodium diets not necessary ■ not contraindicated except in complete renal shutdown ■ *in hypertension*—significant lowering of the blood pressure. Naturetin may be used alone or with other antihypertensive drugs in lowered doses.

Supplied: Naturetin Tablets, 5 mg. (scored) and 2.5 mg. Naturetin c̄ K (5 c̄ 500) Tablets (capsule-shaped) containing 5 mg. benzydroflumethiazide and 500 mg. potassium chloride. Naturetin c̄ K (2.5 c̄ 500) Tablets (capsule-shaped) containing 2.5 mg. benzydroflumethiazide and 500 mg. potassium chloride.

References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy *5*:60 (Feb.) 1960. 2. Steinberg, E. S., Jr.; Benedetti, A., and Forsham, P. H.: Op. cit. *5*:46 (Feb.) 1960. 3. Fuchs, M.; Moyer, J. H. and Newman, B. E.: Op. cit. *5*:55 (Feb.) 1960. 4. Marriott, H. J. L., and Schamroth, L.: Op. cit. *5*:14 (Feb.) 1960. 5. Ira, G. H., Jr.; Shaw, D. M., and Bogdonoff, M. D.: North Carolina M. J. *21*:19 (Jan.) 1960. 6. Cohen, B. M.: M. Times, to be published. 7. Breneman, G. M., and Keyes, J. W.: Henry Ford Hosp. M. Bull. *7*:281 (Dec.) 1959. 8. Forsham, P. H.: Squibb Clin. Res. Notes *2*:5 (Dec.) 1959. 9. Larson, E.: Op. cit. *2*:10 (Dec.) 1959. 10. Kirkendall, W. M.: Op. cit. *2*:11 (Dec.) 1959. 11. Yu, P. N.: Op. cit. *2*:12 (Dec.) 1959. 12. Weiss, S.; Weiss, J., and Weiss, B.: Op. cit. *2*:13 (Dec.) 1959. 13. Moser, M.: Op. cit. *2*:13 (Dec.) 1959. 14. Kahn, A., and Greenblatt, I. J.: Op. cit. *2*:15 (Dec.) 1959. 15. Grollman, A.: Monographs on Therapy *5*:1 (Feb.) 1960.

SQUIBB

Squibb Quality—the Priceless Ingredient

D) Rose bengal test.
E) Serum cholinesterase levels.

6. A pulse deficit is most likely to occur with:
A) Paroxysmal auricular tachycardia.
B) Rapid fibrillation.
C) Pericardial effusion.
D) Sinus arrhythmia.
E) Auricular-ventricular block.

7. Falsely low serum iodine values may be reported in patients receiving:
A) Mercurial diuretics.
B) Tetracyclines.
C) High doses of vitamin B_{12}.
D) Intramuscular iron.
E) Bal.

8. Low I^{-131} uptake and high protein bound iodine suggest:
A) Acute thyroiditis.
B) Pituitary myxedema.
C) A thyroid storm.
D) Thyrotoxicosis factitia.
E) Thyroid hyperplasia.

9. After total pancreatectomy in man, the daily insulin requirement is:
A) 10 units.
B) Anywhere from 10 to 300 units.
C) 20 to 50 units.
D) 50 to 150 units.
E) 500 units.

10. An abnormality associated with otherwise normal hearts is:
A) Bigeminy.
B) Flutter-fibrillation.
C) Atrioventricular dissociation.
D) Wolf-Parkinson-White syndrome.
E) Left bundle branch block.

11. In tuberculosis there is often elevation of serum:
A) Albumin.
B) Factor five.
C) Alpha-2 globulins.
D) Gamma globulin.
E) Fibrinogen.

12. The erythrocyte sedimentation rate is an index of activity in:

A) Rheumatoid spondylitis.
B) Histoplasmosis.
C) Ochronosis.
D) Boeck's sarcoid.
E) Oroya fever.

13. In order for bacterial growth to take place, which one of the following substances must be added to a blood culture taken from a patient who has received streptomycin?

A) Peptone broth.
B) Clarase.
C) Para-amino benzoic acid.
D) Streptodornase.
E) Cysteine.

14. Cells with an eccentric cart-wheel nucleus and an adjoining clear area are called:

A) Gitter cells.
B) Sternberg-Reed cells.
C) Plasma cells.
D) Kupffer cells.
E) Leydig cells.

15. Among macrophages found in areas of softening in the brain are:

A) Epithelioid cells.
B) Gitter cells.
C) Schlemm cells.
D) Kupffer cells.
E) Leydig cells.

16. Leukocytes can pass into tissues through:

A) Capillaries only.
B) Anoxic vessel walls only.
C) Necrotic membranes.
D) Ruptured vessel walls only.
E) Intact vessel walls.

17. Administration of ACTH to a patient with classic adrenogenital syndrome increases urinary:

A) Pregnanetriol.
B) Aldosterone.
C) 17-hydroxy corticosteroids.
D) Progesterone.
E) 17-hydroxy indole - acetic acid.

18. Decreased leukocytic alkaline phosphatase and increased serum Vitamin B_{12} occur in:

A) Polycythemia vera.
B) Infectious mononucleosis.
C) Leukemoid reaction.
D) Chronic myelogenous leukemia.
E) Acute lymphocytic leukemia.

19. Bradydactylia plus failure to diurese after intravenous parathormone suggests:

A) Pseudohypoparathyroidism.
B) Hypervitaminosis D.

C) Rickets.
D) Secondary hyperparathyroidism.
E) Primary hyperparathyroidism.

20. Necrotizing pneumonitis and tenacious sputum in an alcoholic suggest:
A) Friedländer's pneumonia.
B) Aspergillosis.
C) Q fever.
D) Mucoviscidosis.
E) Influenza.

21. Brill's disease is caused by:
A) R. Prowazeki.
B) R. Mooseri.
C) E. Typhosa.
D) D. Rickettsia.
E. R. Typhimurium.

22. In acute hepatic necrosis the serum Vitamin B_{12} level:
A) Is essentially unaffected.
B) Varies with the nutritional state.
C) Falls.
D) Varies with the icteric index.
E) Rises markedly.

(answers on page 162)

What's the Doctor's Name?

He was born November 21, 1729, at Amesbury, Mass., and died May 19, 1795.

At the age of 16 he began the study of medicine in the office of a kinsman, Dr. Ordway, and started practice in 1750, in the town of Kingston, N.H.

Married Mary Barton on January 15, 1754. They had twelve children; three of their sons and seven of their grandsons became physicians.

At the Continental Congress, as a delegate from New Hampshire (1775-76) he was the first to give his vote in favor of the adoption of the Declaration of Independence, to which his name was duly affixed. He also had the honor of being first to vote for the proposed Articles of Confederation and Perpetual Union which took effect March 1, 1781.

In 1779, New Hampshire appointed him chief justice of its Court of Common Pleas. In 1782, he was promoted to associate justice of the Superior Court, became chief justice in 1788, and ended his service on the bench in 1790.

In 1790, and in each of the two following years, he was elected to the highest office in the state, that of chief executive (then called "president"). In June 1793, the newly amended state constitution having changed the title, he was chosen as the first governor of the state.

In 1790, Dartmouth College conferred upon him the honorary degree of Doctor of Medicine.

He was elected first president of the New Hampshire Medical Society.

His portrait in oil was painted by Jonathan Trumbull, and a bronze statute of him, unveiled in 1888, stands in the public square of his native town. Can you name this doctor? *Answer on page 162.*

VIEWBOX DIAGNOSIS

(from page 25)

ECHINOCOCCUS CYST OF LIVER.
Notice the calcified cyst in the liver. Echinococcus is endemic in Greece.

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MEDIQUIZ ANSWERS

(from page 156)

1 (D), 2 (C), 3 (A), 4 (B), 5 (E), 6 (B), 7 (A), 8 (D), 9 (C), 10 (D), 11 (C), 12 (A), 13 (E), 14 (C), 15 (B), 16 (E), 17 (A), 18 (D), 19 (A), 20 (A), 21 (A), 22 (E).

•

WHAT'S THE DOCTOR'S NAME

(answer from page 161)

JOSIAH BARTLETT

•

RESIDENT RELAXER

(puzzle on page 29)